



SUPERIOR DENTAL CARE EMPLOYER GROUP APPLICATION

LEADING THE WAY IN DENTAL BENEFITS

General Information:

Name of Group: _____ (DBA) _____ Total Employees: _____
 # of Eligible Employees: _____
 Address: _____ Group Tax ID#: _____
 City/State/Zip: _____ County: _____ Phone: _____
 Industry: _____ SIC Code: _____ Fax: _____

Contacts: (please include titles)

Administration: _____ Title: _____ Email: _____
 Enrollment: _____ Title: _____ Email: _____
 Superior Direct Connect: _____ Title: _____ Email: _____
To sign up for Superior Direct Connect, our online account management system, please go to our website at superiordental.com
 Billing: _____ Title: _____ Email: _____

Automatic Deduction of Fees / Premiums, please complete the form on the back and attach a voided check.

Eligibility Information: Dependents are covered to the maximum age of: _____ (SDC permits up to age 26 through the end of the **birth month**).

Contribution Level: Employer Pays: _____ EE Pays: _____

Effective Date: _____
Renewal Date: _____

Based on the SDC rate sheet and plan options available, please complete the information below. If one plan has been selected, please list the plan information in the first column below. If 2 or 3 plans are selected, please use the columns below starting with the first.

SDC-Kids plan:

- Low Plan
 - High Plan
- Network Option:**
- Open Access (In & Out of Network)
 - Point of Service
 - Network Only

Plan design:

	Plan: _____	Plan: _____	Plan: _____
	In Network / Out of Network	In Network / Out of Network	In Network / Out of Network
Preventive	_____ % / _____ %	_____ % / _____ %	_____ % / _____ %
Basic	_____ % / _____ %	_____ % / _____ %	_____ % / _____ %
Major	_____ % / _____ %	_____ % / _____ %	_____ % / _____ %
Contract Maximum	\$ _____	\$ _____	\$ _____
Max Adv Yr. 2	\$ _____	\$ _____	\$ _____
Max Adv Yr. 3	\$ _____	\$ _____	\$ _____
Deductible	\$ _____	\$ _____	\$ _____
Copay	\$ _____	\$ _____	\$ _____
Ortho	_____ % / _____ %	_____ % / _____ %	_____ % / _____ %
Ortho Max	\$ _____	\$ _____	\$ _____

Admin fee (if Self-Funded):
ASO Admin Fee: \$ _____

Funding Option:

- Fully-Funded
- Self-Funded

Max Advantage:

- Yes

Superior Vision*:

- Plan #:** _____
- Tied to Dental
 - Employer Paid
 - Voluntary

Vision Rates*:

	Employee \$ _____	EE+Spouse \$ _____	EE+Child(ren) \$ _____	Family \$ _____
Employee	\$ _____	\$ _____	\$ _____	\$ _____
EE+Spouse	\$ _____	\$ _____	\$ _____	\$ _____
EE+Child(ren)	\$ _____	\$ _____	\$ _____	\$ _____
Family	\$ _____	\$ _____	\$ _____	\$ _____

Dental Rates:

	Employee \$ _____	EE+Spouse \$ _____	EE+Child(ren) \$ _____	Family \$ _____
Employee	\$ _____	\$ _____	\$ _____	\$ _____
EE+Spouse	\$ _____	\$ _____	\$ _____	\$ _____
EE+Child(ren)	\$ _____	\$ _____	\$ _____	\$ _____
Family	\$ _____	\$ _____	\$ _____	\$ _____

*Your group must be enrolled in an active SDC dental plan in order to be eligible for a Superior Vision plan.

Approved Association/Chamber Name (if applicable): _____

SDC offers plans to select chambers and associations. For a complete listing, please contact SDC. Note: All association/chamber information will be verified with the designated chamber before the group is installed.

Broker Information:

**Firm Name: _____ Tax ID: _____ NPN#: _____
 Selling Agent Name: _____ Email: _____
 Servicing Agent Name: _____ Email: _____
 Address: _____ City/State/Zip: _____
 Phone: _____ Fax: _____

I agree the commission quoted on the proposal rate sheet is accurate. Signature: _____ Date: _____
 I agree to the standard commission for this community rated plan. Signature: _____ Date: _____

**Commission will be paid to the firm.

If this is your first sale with SDC, please complete and return the **Producer Appointment Information Form**. Please ask your sales representative for details.



AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT

Company Name: _____ **Group Number:** _____

*We hereby authorize **SUPERIOR DENTAL CARE** to initiate debit entries to our account indicated below at the financial institution named below.*

Name on Account: _____

Account Number: _____

Type of account: _____ CHECKING _____ SAVINGS _____

Financial Institution Name: _____

Address: _____

Routing and Transit Number: _____

Please attach a copy of a voided check to ensure proper processing.

*This authorization will remain in full force and effect until **SUPERIOR DENTAL CARE** has received written notification of **ANY** and **ALL** changes **30 DAYS PRIOR** to change date and in such a manner as to afford **SUPERIOR DENTAL CARE** and **BANK** to act upon it.*

NAME OF AUTHORIZED PERSON: _____

SIGNATURE: _____ **DATE:** _____

Please return to:
Superior Dental Care
Attn: Finance Department
6683 Centerville Business Parkway
Centerville, OH 45459