SUPERIOR DENTAL CARE
EMPLOYER GROUP APPLICATION

Superior Dental Care®
A Medical Mutual® Company

LEADING THE WAY IN DENTAL BENEFITS

General Information:

Total Employees: _____

Name of Group: _____ (DBA) _____ # of Eligible Employees: _____

Address: _____ # Est. Enrolled Employees: _____

City/State/Zip: _____ County: _____ Group Tax ID#: _____

Phone: _____ Fax: _____ Industry: _____ SIC Code: _____

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

Funding Option:

☐ Fully-Funded

☐ Self-Funded

Max Advantage:

☐ Yes

Superior Vision*:

Plan #: _____

☐ Tied to Dental

☐ Employer Paid

☐ Voluntary

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	$_____	$_____	$_____

Vision Rates*:

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

Dental Rates:

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

Admin fee (if Self-Funded):

ASO Admin Fee: $_____

or

Direct Admin Fee: $_____

Reimbursement Schedule:

Level 1 _____

Level 2 _____

Level 3 _____

Level 4 _____

Ortho Max $_____

Contract Max $_____

With SDC's Network? ☐Yes ☐No

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

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.

1.13.2022

SUPERIOR DENTAL CARE

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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 (circle one): 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

1.13.2022