SUPERIOR DENTAL CARE

Real Estate Agent Application

LEADING THE WAY IN DENTAL BENEFITS

Company Name: **Real Estate Agent Dental Plan**

Effective Date of Action:_____

Agent Name:_____ Group #: _____ Subgroup #:_____

Address:_____ ☐ Male ☐ Female

City: _____ State:_____ Zip:_____ County:_____ Home Phone #:_____ Alt Phone #:_____

Date of Birth:_____ SS#: _____ E-Mail:_____

Reason for the Form:

☐ New Enrollment / ☐ Open Enrollment ☐ Add / ☐ Delete Dependent & Reason: _____

☐ Subgroup Change ☐ Marriage / ☐ Divorce Date: _____

☐ COBRA Continuation/Conversion ☐ Enrollee Termination & Reason: _____

☐ Waive Coverage ☐ Other: _____

SDC's Group Plan: Choose one the following plans: ☐ **Plan #1076** ☐ **Plan #631**

Full Name	*Relationship*	*Gender*	*Birth Date*	*Waive*	*Other Dental Insurance*
				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N

Other Dental Coverage (if you circled 'Y' in the Other Dental Insurance section above for any of the dependents listed, please complete this section):

Are you, your spouse, or any dependents also covered under another dental policy? ☐ Yes ☐ No If yes, please complete the following: Policy #:_____

Employer Name:_____ Insurance Company:_____

Employer Address:_____ SS #:_____ Birthdate:_____

City:_____ State:_____ Zip:_____ Individuals covered:_____

Signatures:

Enrollee Signature:_____ **Date:**_____

Approved by (Group Administrator):_____ **Date:**_____

Superior Direct Connect - Once your group is enrolled and effective, go to www.superiordental.com, click on Get Connected! and sign up to access your account and personal benefit information.

Notice: Any person obligated for any part of a pre-payment may cancel such agreement within 72-hours after having signed the agreement or offer to enroll. Cancellation occurs when written notice of cancellation is given to SDC or its agents or other representatives.

On behalf of myself and any dependents listed above, I hereby apply for coverage under the Master Group Contract issued to my employer by Superior Dental Care. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any changes provided therein. I understand that certain services may require a co-payment payable by me (or my dependents) directly to the provider of such services. I further understand that covered services may be obtained through any licensed dentist and also that certain services may require a co-payment payable by me (or my dependents) directly to the provider of such services. Superior Dental Care also offers a network only plan. Please refer to the dental contract available through your employer for clarifications on the dental plan currently in place. I authorize my employer to deduct the necessary dental service fees, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with Superior Dental Care and that all acts performed by him and all notices given to him in such dealings are binding upon me, as not prohibited by statute or regulation. In the event that this Application for Coverage is accepted, I authorize my dentist to give, upon request, any information concerning the condition or treatment of any person included under such coverage whenever such information is considered necessary by Superior Dental Care for the proper disposition of a claim submitted for payment or in fulfillment of obligations imposed on Superior Dental Care by state or federal statutes. **Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

April 2016

SUPERIOR DENTAL CARE

AUTOPAY PROGRAM

Real Estate Agent Application

LEADING THE WAY IN DENTAL BENEFITS

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT

Agent's 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 your Group Administrator:

The Scheller Bradford Group
John Harder
463 Ohio Pike Ste 303
Cincinnati, OH 45255
john.harder@schellerbradford.com

April 2016