Please return this form to Human Resources by **Friday, October 13, 2023**

****Open Enrollment: Form is only needed if adding/dropping coverage for yourself or dependent(s). Otherwise, current coverage rolls over.**
**** I understand my enrollment or waiver is irrevocable for plan year unless I have a qualifying event and apply for change within 30 days.**

Company Name:__Clinton County____________

Effective Date of Action: January 1, 2024

SS #:____

Employee Name:____

Address:____

City:_______________________State____Zip_______

E-Mail:____

Phone #:________________________________

Male:_____ **Female:_____**

Date of Birth: ________________________________

REASON FOR THE FORM:

_____New Enrollment ______Waive Coverage **_____Add / _____ Delete Dependent**

DEPENDENTS TO BE Added / Dropped:

Drop/Add	Full Name	Member Code S-Spouse C-Child	Sex (M/F)	Birth Date	Other dental plan
___Drop ___Add					Y / N
___Drop___Add					Y / N
___Drop___Add					Y / N
___Drop___Add					Y / N
___Drop___Add					Y / N

If dependents covered by other dental plan, please complete the following:

Policy # ____

Employer Name: ________________________________ Insurance Company:______________________________

Employer Address:________________________________ SS #:____

City:________________________ ST_____ Zip________ Individuals covered by spouse:_____________________

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 of 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.

Employee Signature: ____