



Complete for Dental Enrollment Only

Please send applications only to:
Medical Mutual
MZ 02-3P-6200
100 American Road
Brooklyn, Ohio 44144

SUPERIOR DENTAL CARE
ENROLLMENT FORM

LEADING THE WAY IN DENTAL BENEFITS

CASE WESTERN RESERVE UNIVERSITY RETIREE

Effective Date of Coverage: _____

Name: _____

Group #: 227922

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Home Phone: _____ Alt Phone: _____

E-Mail: _____

Reason for the Form: ☐ New Enrollment / ☐ Open Enrollment

☐ Add Spouse & Reason: ☐ Marriage Date: _____ ☐ Loss of Other Coverage Date: _____ ☐ Other Qualifying Event: _____

<u>Full Name</u>	<u>Retiree/Spouse</u>	<u>Birth Date</u>	<u>Social Security Number</u>	<u>Gender</u>	<u>Other Dental Insurance (Y/N)</u>
	Retiree				
	Spouse				
	Child				
	Child				
	Child				
	Child				
	Child				

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

Please complete the following: Policy #: _____

Employer Name: _____

Insurance Company: _____

Employer Address: _____

Policy Holder SS #: _____

City: _____ State: _____ Zip: _____

Birthdate: _____

Individuals covered: _____

Signatures:

Enrollee Signature: _____

Date: _____

On behalf of myself and any dependents listed above, I hereby apply for coverage under the Master Group Contract/Policy issued to Case Western Reserve University by Superior Dental Care (SDC). I understand the benefits for which I and my dependents are eligible under this Policy. I understand certain services may require a copayment or deductible payable by me or my spouse directly to the provider of services. I authorize Case Western Reserve University to act as my agent in all dealings with the plan 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. I waive the dentist-patient privilege and authorize my dentist to give SDC, its agents and representatives, any information concerning any claims for reimbursement for covered services of any person under this coverage. In the absence of fraud, all statements under this application are considered representations and not warranties.

OHIO FRAUD NOTICE: 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.

KENTUCKY FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

INDIANA FRAUD NOTICE: Any person who knowingly and with intent to defraud an insurer files an application for insurance containing any false, incomplete, or misleading information commits a felony.

Superior Direct Connect - Once you are enrolled and effective, go to superiordental.com and sign up to access your account and personal benefit information.