Access Mobile Care
A Superior Select Benefit Plan

Underwritten by
Arkansas Superior Select, Inc.

Application for Individual Dental Coverage

Please fax completed application to:
Arkansas Superior Select, Inc.
Fax Number: 1-866-912-1869

PLEASE TYPE OR PRINT IN BLACK INK
BE SURE APPLICATION IS COMPLETED IN FULL
Customer Service: Toll Free Number 1-866-423-0415
SuperiorSelectBenefits.com

This application is for a dental product provided by Arkansas Superior Select, Inc. ("ASSI" "we," "our" or "us") in which Policyholders enroll in Access Mobile Care Dental Plan, authorizing Dentists to perform various covered dental services.

Section 1 | Policyholder Information

Desired Effective Month/Year

_____/_____

Policyholder Last Name	First Name	Middle Initial
Date of Birth	SSN	Gender: ☐ Male ☐ Female

Section 2 | Payment Options

Please select a premium payment option:

☐ Coordinate my payment through the facility ☐ Send me a bill

Section 3 | Facility Information

Name of Nursing/Residential Care/Assisted Living Facility	City

Section 4 | Application Signature

By signing the line below, you are agreeing to the Acknowledgement section listed on the back of this application.

_____ _____

Policyholder/Representative Signature **Date**

If you are the **authorized representative**, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee: _____

Section 5 | Acknowledgement

In submitting this application to ASSI for dental coverage, I understand that if my application is accepted, my contract will consist of the Policy issued to me, along with a Policy Schedule containing information about my coverage, such as my premium and effective date. I understand that I am required to pay premium for the duration of the contract. I further agree that the coverage requested is subject to the approval of ASSI, that no coverage shall become effective until ASSI receives my initial premium and that no representative has authority to make changes or modify this application.

I certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that misrepresentation of submitted data may cause this application and subsequent Policy to be null and void. I understand that the Policy will become effective on the first day of the month following approval of this application and ASSI's receipt of the initial premium.

By my submission of this application, I attest that I am a resident of a nursing, residential care or assisted living facility in Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit to an insurer or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.