

# DOMINION DENTAL SERVICES, INC. ENROLLMENT CARD

**SELECT ONE:**     **Select Plan**  
 **Access PPO**

## Enrollment Information

Last Name		First Name		M.I.
Social Security Number		Sex	<input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (MM/DD/YY)
Home Address			Home Phone	
City	State	ZIP	Work Phone	
Email Address			Hire Date	

## List All Your Eligible Dependents Below

Last name (if different)	First Name	M.I.	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse				
Child				
Child				
Child				
Child				
Child				
Child				

<b>SELECT PLAN</b>	Dental Office Name & Code #
Provider Selection	(As Indicated on Your Dentist Directory)

If I am enrolling in the SELECT Plan and I am voluntarily paying 100% of the cost of this Plan, without employer contribution, I agree to remain in Plan a minimum of twelve (12) months. If I cancel before the end of the 12 month period, I may be responsible for the usual, customary and reasonable charges for services received, reduced by the sum of the subscription dues and copayments paid. I understand and agree that my signature on this enrollment form serves as my legal commitment to the Plan and its terms. Further, this signature represents my authorization for the release of information regarding services provided to me or my covered dependents by dentists and other providers of dental services. Information will be released to Dominion Dental Services, Inc., for the purpose of Quality Assurance and/or utilization review. Authorization will be limited to the term of coverage of this contract. A copy of this form will be made available to subscriber or their authorized representative upon request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent/Broker #	Group #	Group Name	Coverage Eff. Date
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**Dominion Dental Services, Inc., P.O. Box 75314 Charlotte, NC 28275-5314**

**District of Columbia** - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **Maryland** - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Pennsylvania** - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Virginia** - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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