Dominion Dental Services, Inc.
Alexandria, VA

Enrollment Card

SELECT ONE: ☐ Select Plan
☐ Access PPO

Enrollment Information

Last Name	First Name	M.I.
Social Security Number	Sex ☐ M ☐ 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.	Social Security Number	Sex (M/F)	Birthdate (MM/DD/YY)
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					

SELECT PLAN
Provider Selection

Dental Office Name & Code #
(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 investigation or evaluation of care in connection with a claim or complaint. 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 _____

PAPERLESS? ☐ Yes ☐ No

Agent/Broker #	Group #	Group Name	Coverage Eff. Date
		Virginia Commonwealth University	

Dominion Dental Services, P.O. Box 75314 Charlotte, NC 28275-5314

Delaware - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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.

DCAPP12