DOMINION[SM] USA

115 South Union Street, Suite 300
Alexandria, VA 22314
Customer Service: 800-334-6277
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DominionDental.com

EMPLOYEE ENROLLMENT AND CHANGE FORM

PLEASE PRINT OR TYPE -
BE SURE FORM IS COMPLETED
IN FULL TO ENSURE ENROLLMENT

EMPLOYEE PLEASE GIVE YOUR COMPLETED FORM TO YOUR BENEFITS ADMINISTRATOR

ADMINISTRATOR PLEASE MAIL COMPLETED ENROLLMENT FORMS TO:

115 South Union Street
Suite 300
Alexandria, VA 22314

1. EMPLOYER NAME: EAA	2. EFFECTIVE DATE:	3. DATE OF HIRE:	4. GROUP NUMBER:
5. LAST NAME (Subscriber):	6. FIRST NAME:	7. SOCIAL SECURITY NO.	8. DOB:
9. HOME ADDRESS	10. CITY:	11. STATE:	12. ZIP:

13. PLAN SELECTION

☐ **Access** ☐ **Choice** ☐ **Access ePPO Schedule A** ☐ **Access ePPO Schedule C** ☐ **Select**

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) COVERED UNDER YOUR POLICY

14. FIRST NAME	15. LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	16. DATE OF BIRTH	17. CHECK IF DEPENDENT IS OVER 19 AND A FULL TIME STUDENT
SPOUSE			
CHILDREN			

18. REASON FOR SUBMISSION

☐ New Coverage
☐ Individual ☐ Individual + 1/Spouse ☐ Individual + Child ☐ Family
☐ Termination
☐ Add dependent
☐ Reinstatement
☐ Remove dependent _____ name
☐ Name change
☐ Address change
☐ Remove dep. from student status _____ name

☐ Transfer from sublocation _____ to _____
☐ Status change: From _____ to _____

COBRA
☐ Reinstatement of Subscriber
☐ Individual ☐ Individual + 1/Spouse ☐ Individual + Child ☐ Family
__ Transfer to Cobra Sublocation _____
__ New addition of dependent formerly covered under ID # _____

19. COORDINATION OF BENEFITS

Upon the effective date of this coverage will you or any of your eligible dependents listed above be covered by another dental plan? ☐ No ☐ Yes

If YES, please indicate name of covered individual _____.

OTHER DENTAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE

20. Are you or any of your eligible dependents (listed above) covered by a medical plan? ☐ No ☐ Yes

If YES, please indicate name of covered individual _____.

NAME OF MEDICAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Dominion USA, Inc. In addition, if my employer requires employee contributions for this coverage, I authorize the deduction of this amount from my wages.

21. Subscriber Signature _____ Date _____ Benefit Administrator Authorization _____ Date _____

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.