**Dominion Dental Services, Inc.**
**Arlington, VA**

**Avalon Insurance Company**
**Harrisburg, PA**

## Dental/Vision Enrollment Card

**DENTAL** **SELECT ONE:**
- ☐ I choose the Dominion PPO[1]
- ☐ I choose the Dominion ePPO[1]
- ☐ I choose the Dominion Select Plan[1]

**VISION** **SELECT ONE:**
- ☐ I choose the Avalon vision[2] plan

## 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. | 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 providers of dental and/or vision services. Information will be released to Dominion Dental Services, Inc., if enrolled in the dental plan and Avalon Insurance Company if enrolled in vision plan, 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 _____

| Agent/Broker # | Group # | Group Name | Coverage Eff. Date |
|---|---|---|---|
| | | SF&C Block Transfer (707xs) | |

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

[1] The dental plans are underwritten by Dominion Dental Services, Inc.
[2] The vision plans are underwritten by Avalon Insurance Company and administered by Dominion Vision Services.

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 - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit 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. 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.

PAYROLL DEDUCTION AUTHORIZATION

| AGENCY CODE | SOCIAL SECURITY NO. | EMPLOYEE NAME |
|---|---|---|
| [redacted] XX | [redacted] | |

| DEDUCTION ACTION REQUESTED — CHECK ONE | | | | OLD AMOUNT | NEW AMOUNT | TO BE DEDUCTED | BEGINNING |
|---|---|---|---|---|---|---|---|
| INITIATE | INCREASE | DECREASE | CANCEL | | | BI-WEEKLY | PAY PERIOD ENDING |
| | | | | $ | $ | MONTHLY | |

You are hereby authorized to deduct from my salary the above insurance premium and forward it to S.F. & C. Insurance Associates, Inc.

This deduction will begin on the pay period specified above and will continue for each pay period until written notice to change or cancel is submitted by memo on a new authorization card.

*S.F. & C. Authorization Stamp*



DATE _____ EMPLOYEE SIGNATURE _____

**NOTE:** AN AUTHORIZED CARD MUST BE ON FILE WITH THE CENTRAL PAYROLL BUREAU FOR EACH AUTHORIZED DEDUCTION AND A NEW CARD MUST BE FILED FOR EACH DEDUCTION CHANGE.

stc-c1015