



Altus Dental Insurance Company, Inc.

ENROLLMENT FORM

Please print.

P.O. Box 1557
Providence, RI 02901-1557
877-223-0588

Employer Group Name		Altus Dental Group Number		Date of Hire	Location No. (if applicable)
Social Security No. / Subscriber ID No.		Subscriber Name: First - Last			Email Address
Date of Birth - MM/DD/YYYY		Street Address / P.O. Box No.			
Effective Date of Action:		Apt. No.	City	State	Zip

QUALIFYING EVENT

<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> New Hire/Re-Hire	<input type="checkbox"/> Return From Leave of Absence
<input type="checkbox"/> Marriage	<input type="checkbox"/> Dependent's Loss of Coverage
<input type="checkbox"/> Divorce	<input type="checkbox"/> Full-Time/Part-Time Status
<input type="checkbox"/> Birth or Adoption	<input type="checkbox"/> Death of a Member

DEPENDENT INFORMATION			
First Name Only	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
If last name differs, please indicate in "other remarks" below.			<input type="checkbox"/>
			<input type="checkbox"/>

ACTION CODE (Check one. Changes must be made on the first of the month.)

ADDITIONS:

New Subscriber

Add Dependent to Family

Reinstatement

TERMINATION:

Remove Subscriber

Remove Dependent / Student

STATUS CHANGE:

Change "Type of Coverage"

Please indicate (e.g. Individual to Family) under "Type of Coverage".

Name / Address Change

Transfer from Sublocation # _____ to # _____

COBRA:

Reinstatement of Subscriber

Addition of Dependent — (From prior ID # _____)

DENTIST INFORMATION

List the dentists you or your covered family members use:

Dentist(s) Last Name	First Name	City/Town

CORRECTIONS / OTHER REMARKS

TYPE OF COVERAGE (Check one)	PLAN TYPE (Please check box if applicable.)
<input type="checkbox"/> Individual <input type="checkbox"/> Family	<input type="checkbox"/> High Option <input type="checkbox"/> Low Option

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? No Yes If Yes, Please Complete the Section Below.

Other Dental Insurance Name: _____ Type of Coverage: Individual Family

Other Dental Insurance Address: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.
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MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? No Yes If Yes, Please Complete the Section Below.

Name of Medical Insurance Company / HMO: _____ Type of Coverage: Individual Family

Name of Health Plan / Type of Coverage: _____

Employer Name Through Which You / Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.
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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 Altus Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____	Date _____	Benefits Administrator Authorization _____	Date _____
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