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 I.D. No.	Subscriber Name: First - Last
Date of Birth - MM/DD/YYYY	**Street Address / P.O. Box No.**

Effective Date of Action:	Apt. No.	City	State	Zip

QUALIFYING EVENT

- ____ Open Enrollment
- ____ New Hire/Re-hire
- ____ Marriage
- ____ Divorce
- ____ Birth or Adoption
- ____ Workers' Compensation
- ____ Return From Leave of Absence
- ____ Dependent's Loss of Coverage
- ____ Full-Time/Part-Time Status
- ____ Death of a Member

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 change (e.g. Individual to Family) in the section below.
- ____ Name / Address Change
- ____ Transfer from Sublocation #_____ to #_____

COBRA:

- ____ Reinstatement of Subscriber
- ____ Addition of Dependent — (From prior ID # _____)

DEPENDENT INFORMATION

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

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)
☐ Individual ☐ Family

PLAN TYPE (Please check box if applicable.)
☐ High Option ☐ 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.**

Type of Coverage: ☐ Individual ☐ Family

Other Dental Insurance Name: _____

Other Dental Insurance Address: _____

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

Group Policy No.	Policyholder Name	Policyholder ID No.

MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? ☐ No ☐ Yes **If Yes, Please Complete the Section Below.**

Type of Coverage: ☐ Individual ☐ Family

Name of Medical Insurance Company/HMO: _____

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.

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