

**Altus Dental Insurance Company, Inc.**  
 PO Box 1557  
 Providence, RI 02901-1557  
 877-223-0588

| <b>GROUP INFORMATION</b> <i>To be completed by Human Resources or Benefit Administrator.</i> |                     |              |                              |
|--|---------------------|--------------|------------------------------|
| Employer / Group Name  |                     |              | Group No.                    |
| Dental Division No.  | Vision Division No. | Date of Hire | Location No. (if applicable) |

**I. SUBSCRIBER INFORMATION**

|                               |  |                            |                 |                          |     |
|-------------------------------|--|----------------------------|-----------------|--------------------------|-----|
| Subscriber Name (First, Last) |  | Date of Birth (MM/DD/YYYY) |                 | Social Security / I.D. # |     |
| Street Address / P.O. Box No. |  | Apt. No.                   | City            | State                    | Zip |
| Preferred Mobile Number       |  |                            | Preferred Email |                          |     |

**II. ENROLLMENT INFORMATION**

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| Effective Date of Action (MM/DD/YYYY)   |  | <b>TYPE OF COVERAGE</b><br><i>Check all that apply.</i>                      |  |  |   |
|   |  | <input type="checkbox"/> Dental<br><input type="checkbox"/> Vision           |  |  |   |
| <b>QUALIFYING EVENT</b>                 | <input type="checkbox"/> Open Enrollment         | <input type="checkbox"/> Marriage  | <input type="checkbox"/> Birth or Adoption                         | <input type="checkbox"/> Return from Leave of Absence              | <input type="checkbox"/> Full-Time/Part-Time Status |
|   | <input type="checkbox"/> New Hire/Re-hire        | <input type="checkbox"/> Divorce   | <input type="checkbox"/> Workers' Compensation                     | <input type="checkbox"/> Loss of Coverage                          | <input type="checkbox"/> Death of a Member          |
| <b>ACTION CODE</b><br><i>Check one.</i> | <u>ADDITIONS</u>                                 | <u>TERMINATION</u>   | <u>STATUS CHANGE</u>   | <u>COBRA</u>   |   |
|   | <input type="checkbox"/> New Subscriber          | <input type="checkbox"/> Remove Subscriber                                   | <input type="checkbox"/> Name / Address Change                     | <input type="checkbox"/> Reinstatement of Subscriber               |   |
|   | <input type="checkbox"/> Add Dependent to Family | <input type="checkbox"/> Remove Dependent<br><i>List name in Section III</i> | <input type="checkbox"/> Transfer from Division # _____ to # _____ | <input type="checkbox"/> Addition of Dependent<br>Prior ID # _____ |   |
|   | <input type="checkbox"/> Reinstatement           |  | <input type="checkbox"/> Change Type of Coverage                   |  |   |

**III. DEPENDENT INFORMATION**

| First Name | Last Name (if different) | Date of Birth (MM/DD/YYYY) | Relationship | Enroll In:               |                          |
|------------|--------------------------|----------------------------|--------------|--------------------------|--------------------------|
|            |                          |                            |              | Dental                   | Vision                   |
|            |                          |                            |              | <input type="checkbox"/> | <input type="checkbox"/> |
|            |                          |                            |              | <input type="checkbox"/> | <input type="checkbox"/> |
|            |                          |                            |              | <input type="checkbox"/> | <input type="checkbox"/> |
|            |                          |                            |              | <input type="checkbox"/> | <input type="checkbox"/> |
|            |                          |                            |              | <input type="checkbox"/> | <input type="checkbox"/> |
|            |                          |                            |              | <input type="checkbox"/> | <input type="checkbox"/> |

I certify that all information is correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with underwriting guidelines. 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 \_\_\_\_\_

**NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY**

Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**Español (Spanish):** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.