



ENROLLMENT FORM

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

Please print.

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			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		DEPENDENT INFORMATION					
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire/Re-hire <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Return From Leave of Absence <input type="checkbox"/> Dependent's Loss of Coverage <input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Death of a Member		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.
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
ACTION CODE (Check one. Changes must be made on the first of the month.)							
ADDITIONS:							
<input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement							
TERMINATION:							
<input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student							
STATUS CHANGE:							
<input type="checkbox"/> Change "Type of Coverage" Please indicate change (e.g. Individual to Family) in the section below. <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____							
COBRA:		TYPE OF COVERAGE (Check one)				PLAN TYPE	
<input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent — (From prior ID # _____)		<input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Family <input type="checkbox"/> Individual & Child(ren)				(Please check box if applicable.) <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? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.							
Other Dental Insurance Name: _____						Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family	
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? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.							
Name of Medical Insurance Company/HMO: _____						Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> 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.		

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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SUBMIT TO ALTUS DENTAL

