

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.		Email Address	
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	DEPENDENT INFORMATION <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:40%;">First Name Only If last name differs, please indicate in "other remarks" below.</th> <th style="width:15%;">Date of Birth</th> <th style="width:20%;">Relationship</th> <th style="width:25%;">Check box if full-time student over 19. Group must have student rider.</th> </tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">☐</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">☐</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">☐</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">☐</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">☐</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">☐</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">☐</td></tr> <tr><td> </td><td> </td><td> </td><td style="text-align: center;">☐</td></tr> </table>	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.				☐				☐				☐				☐				☐				☐				☐				☐
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ACTION CODE (Check one. Changes must be made on the first of the month.) ADDITIONS: ☐ New Subscriber ☐ Add Dependent to Family ☐ Reinstatement	DENTIST INFORMATION List the dentists you or your covered family members use: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:40%;">Dentist(s) Last Name</th> <th style="width:30%;">First Name</th> <th style="width:30%;">City/Town</th> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	Dentist(s) Last Name	First Name	City/Town																																	
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TERMINATION: ☐ Remove Subscriber ☐ Remove Dependent / Student	CORRECTIONS / OTHER REMARKS 																																				
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 # _____	TYPE OF COVERAGE (Check one) ☐ Individual ☐ 2 Person ☐ Family																																				
COBRA: ☐ Reinstatement of Subscriber ☐ Addition of Dependent — (From prior ID # _____)																																					

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.	

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.	

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 _____