altus dental™
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 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

_____ 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 Existing Family Coverage
_____ Reinstatement

TERMINATION:

_____ Remove Subscriber
_____ Remove Dependent / Student

STATUS CHANGE:

_____ Individual to Family
_____ Family to Individual
_____ 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.
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			☐

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**

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** _____

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 1-800-843-3582.

Português (Portuguese): ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.

SUBMIT TO ALTUS DENTAL