



# ENROLLMENT FORM

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

Please print.

<b>Employer Group Name</b>		<b>Altus Dental Group Number</b>		<b>Date of Hire</b>		<b>Location No. (if applicable)</b>																																					
<b>Social Security No. / Subscriber I.D. No.</b>		<b>Subscriber Name: First - Last</b>			<b>Email Address</b>																																						
<b>Date of Birth - MM/DD/YYYY</b>		<b>Street Address / P.O. Box No.</b>																																									
<b>Effective Date of Action:</b>		<b>Apt. No. City</b>		<b>State</b>		<b>Zip</b>																																					
<b>QUALIFYING EVENT</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> New Hire/Re-hire <input type="checkbox"/> Return From Leave of Absence <input type="checkbox"/> Marriage <input type="checkbox"/> Dependent's Loss of Coverage <input type="checkbox"/> Divorce <input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Death of a Member				<b>DEPENDENT INFORMATION</b>																																							
<b>ACTION CODE</b> (Check one. Changes must be made on the first of the month.)  <b>ADDITIONS:</b> <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Existing Family Coverage <input type="checkbox"/> Reinstatement				<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">First Name Only <small>If last name differs, please indicate in "other remarks" below.</small></th> <th style="width: 15%;">Date of Birth</th> <th style="width: 15%;">Relationship</th> <th style="width: 10%;"><small>Check box if full-time student over 19. Group must have student rider.</small></th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>				First Name Only <small>If last name differs, please indicate in "other remarks" below.</small>	Date of Birth	Relationship	<small>Check box if full-time student over 19. Group must have student rider.</small>				<input type="checkbox"/>																												
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<b>TERMINATION:</b> <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student				<b>DENTIST INFORMATION</b> <small>List the dentists you or your covered family members use:</small>																																							
<b>STATUS CHANGE:</b> <input type="checkbox"/> Individual to Family <input type="checkbox"/> Family to Individual <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____				<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Dentist(s) Last Name</th> <th style="width: 30%;">First Name</th> <th style="width: 40%;">City/Town</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>				Dentist(s) Last Name	First Name	City/Town																																	
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<b>COBRA:</b> <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent — (From prior ID # _____ )				<b>CORRECTIONS / OTHER REMARKS</b>  <b>TYPE OF COVERAGE</b> (Check one) <input type="checkbox"/> Individual <input type="checkbox"/> Family																																							
<b>COORDINATION OF BENEFITS</b>																																											
<b>DENTAL</b> — 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: _____																																											
<b>Group Policy No.</b>		<b>Policyholder Name</b>			<b>Policyholder ID No.</b>																																						
<b>MEDICAL</b> — 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: _____																																											
<b>Group Policy No.</b>		<b>Policyholder Name</b>			<b>Policyholder ID No.</b>																																						

*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 \_\_\_\_\_