



# 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>Date of Birth - MM/DD/YYYY</b>		<b>Street Address / P.O. Box No.</b>		
<b>Effective Date of Action:</b>	<b>Apt. No.</b>	<b>City</b>	<b>State</b>	<b>Zip</b>

**QUALIFYING EVENT**

<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>First Name Only</b> <small>If last name differs, please indicate in "other remarks" below.</small>	<b>Date of Birth</b>	<b>Relationship</b>	<b>Check box if full-time student over 19. Group must have student rider.</b>
			<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)*  
 Explain in "Other Remarks" if necessary.

**ADDITIONS:**

New Subscriber

Add Dependent to Existing Family Coverage

Reinstatement

**TERMINATION:**

Remove Subscriber

Remove Dependent / Student (List dependent name.)

**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 # \_\_\_\_\_)

**DENTIST INFORMATION**

List the dentists you or your covered family members use:

Dentist(s) Last Name	First Name	City/Town

**CORRECTIONS / OTHER REMARKS**

(Please Explain)

**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.
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**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.
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*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 \_\_\_\_\_