

Altus Dental Insurance Company, Inc.
 PO Box 1557
 Providence, RI 02901-1557
 877-223-0588

GROUP INFORMATION <i>To be completed by Human Resources or Benefit Administrator.</i>			
Employer / Group Name			Group No.
Dental Division No.	Vision Division No.	Date of Hire	Location No. (if applicable)

I. SUBSCRIBER INFORMATION

Subscriber Name (First, Last)		Date of Birth (MM/DD/YYYY)		Social Security / I.D. #	
Street Address / P.O. Box No.		Apt. No.	City	State	Zip
Preferred Mobile Number			Preferred Email		

II. ENROLLMENT INFORMATION

Effective Date of Action (MM/DD/YYYY)		TYPE OF COVERAGE <i>Check all that apply.</i>			
		<input type="checkbox"/> Dental <input type="checkbox"/> Vision			
QUALIFYING EVENT	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth or Adoption	<input type="checkbox"/> Return from Leave of Absence	<input type="checkbox"/> Full-Time/Part-Time Status
	<input type="checkbox"/> New Hire/Re-hire	<input type="checkbox"/> Divorce	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Loss of Coverage	<input type="checkbox"/> Death of a Member
ACTION CODE <i>Check one.</i>	<u>ADDITIONS</u>	<u>TERMINATION</u>	<u>STATUS CHANGE</u>	<u>COBRA</u>	
	<input type="checkbox"/> New Subscriber	<input type="checkbox"/> Remove Subscriber	<input type="checkbox"/> Name / Address Change	<input type="checkbox"/> Reinstatement of Subscriber	
	<input type="checkbox"/> Add Dependent to Family	<input type="checkbox"/> Remove Dependent <i>List name in Section III</i>	<input type="checkbox"/> Transfer from Division # _____ to # _____	<input type="checkbox"/> Addition of Dependent Prior ID # _____	
	<input type="checkbox"/> Reinstatement		<input type="checkbox"/> Change Type of Coverage		

III. DEPENDENT INFORMATION

First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Enroll In:	
				Dental	Vision
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

I certify that all information is correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with underwriting guidelines. 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 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.