altus dental

Altus Dental Insurance Company, Inc.

ENROLLMENT FORM

Please print.

Employer Group Name	Altus Dental Group Number	Date of Hire	Location No. (if applicable)

Social Security No. / Subscriber ID 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   _____ Workers' Compensation

_____ New Hire/Re-Hire   _____ Return From Leave of Absence

_____ Marriage   _____ Dependent's Loss of Coverage

_____ Divorce   _____ Full-Time/Part-Time Status

_____ Birth or Adoption   _____ Death of a Member

ACTION CODE (Check one. *Changes must be made on the first of the month.*)

ADDITIONS:

_____ New Subscriber

_____ Add Dependent to Family

_____ Reinstatement

TERMINATION:

_____ Remove Subscriber

_____ Remove Dependent / Student

STATUS CHANGE:

_____ Change "Type of Coverage"
Please indicate (e.g. Individual to Family) under "Type of Coverage".

_____ 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.
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

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)   **PLAN TYPE** (Please check box if applicable.)

☐ Individual   ☐ Family   ☐ High Option   ☐ Low Option

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by <u>Another Dental</u> 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