altus dental™ | Altus Vision™

ENROLLMENT FORM

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

GROUP INFORMATION *To be completed by Human Resources or Benefit Administrator.*

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** *Check all that apply.*	
	☐ Dental Preventive Plan	☐ Vision
	☐ Dental Low Plan	
	☐ Dental High Plan	

QUALIFYING EVENT

☐ Open Enrollment ☐ Marriage ☐ Birth or Adoption ☐ Return from Leave of Absence ☐ Full-Time/Part-Time Status
☐ New Hire/Re-hire ☐ Divorce ☐ Workers' Compensation ☐ Loss of Coverage ☐ Death of a Member

ACTION CODE
Check one.

ADDITIONS	TERMINATION	STATUS CHANGE	COBRA
☐ New Subscriber	☐ Remove Subscriber	☐ Name / Address Change	☐ Reinstatement of Subscriber
☐ Add Dependent to Family	☐ Remove Dependent *List name in Section III*	☐ Transfer from Division #_____ to #_____	☐ Addition of Dependent Prior ID # _____
☐ Reinstatement		☐ Change Type of Coverage	

III. DEPENDENT INFORMATION

First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Enroll In: Dental	Enroll In: Vision
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

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