

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 <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			DEPENDENT INFORMATION		
			First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship
ACTION CODE (Check one. Changes must be made on the first of the month.)					<input type="checkbox"/>
ADDITIONS: <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement					<input type="checkbox"/>
TERMINATION: <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student					<input type="checkbox"/>
STATUS CHANGE: <input type="checkbox"/> Change "Type of Coverage" Please indicate (e.g. Individual to Family) under "Type of Coverage". <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____					<input type="checkbox"/>
COBRA: <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> 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		
			TYPE OF COVERAGE (Check one) <input type="checkbox"/> Individual <input type="checkbox"/> 2 Person <input type="checkbox"/> Family		
COORDINATION OF BENEFITS					
DENTAL — 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: _____					
Group Policy No.		Policyholder Name		Policyholder ID No.	
MEDICAL — 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: _____					
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 _____