

# ENROLLMENT FORM

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>Email Address</b>	
<b>Effective Date of Action:</b>		<b>Apt. No.</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>QUALIFYING EVENT</b> <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> If last name differs, please indicate in "other remarks" below.	<b>Date of Birth</b>	<b>Relationship</b>
<b>ACTION CODE</b> (Check one. Changes must be made on the first of the month.)			<b>DENTIST INFORMATION</b>		
			List the dentists you or your covered family members use:		
<b>ADDITIONS:</b> <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement			<b>Dentist(s) Last Name</b>	<b>First Name</b>	<b>City/Town</b>
			<b>CORRECTIONS / OTHER REMARKS</b>		
<b>TERMINATION:</b> <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student			<b>TYPE OF COVERAGE</b> (Check one) <input type="checkbox"/> Individual <input type="checkbox"/> 2 Person <input type="checkbox"/> Family		
			<b>COORDINATION OF BENEFITS</b>		
<b>STATUS CHANGE:</b> <input type="checkbox"/> Change "Type of Coverage" Please indicate change (e.g. Individual to Family) in the section below. <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____			<b>DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, Please Complete the Section Below.</b>		
			Other Dental Insurance Name: _____ <b>Type of Coverage:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Family Other Dental Insurance Address: _____ Employer Name Through Which You /Your Dependents Have Other Insurance: _____		
<b>COBRA:</b> <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent — (From prior ID # _____ )			<b>MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, Please Complete the Section Below.</b>		
			Name of Medical Insurance Company / HMO: _____ <b>Type of Coverage:</b> <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: _____		
<b>Group Policy No.</b>		<b>Policyholder Name</b>		<b>Policyholder ID No.</b>	
<b>Group Policy No.</b>		<b>Policyholder Name</b>		<b>Policyholder ID No.</b>	

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 \_\_\_\_\_