

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

GROUP INFORMATION		
Employer / Group Name		Group No.
Dental 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 one.</i> <input type="checkbox"/> Dental Low Plan <input type="checkbox"/> Dental High Plan			
QUALIFYING EVENT	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire/Re-hire	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce	<input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Return from Leave of Absence <input type="checkbox"/> Loss of Coverage	<input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Death of a Member
ACTION CODE <i>Check one.</i>	<u>ADDITIONS</u> <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement	<u>TERMINATION</u> <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent <i>List name in Section III</i>	<u>STATUS CHANGE</u> <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Division # _____ to # _____		<u>COBRA</u> <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent Prior ID # _____

III. DEPENDENT INFORMATION

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