

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 ☐ Dental		
QUALIFYING EVENT	☐ Open Enrollment ☐ New Hire/Re-hire	☐ Marriage ☐ Divorce	☐ Birth or Adoption ☐ Workers' Compensation	☐ Return from Leave of Absence ☐ Loss of Coverage ☐ Full-Time/Part-Time Status ☐ Death of a Member
ACTION CODE	<u>ADDITIONS</u> Check one. ☐ New Subscriber ☐ Add Dependent to Family ☐ Reinstatement	<u>TERMINATION</u> ☐ Remove Subscriber ☐ Remove Dependent List name in Section III	<u>STATUS CHANGE</u> ☐ Name / Address Change ☐ Transfer from Division #_____ to #_____	<u>COBRA</u> ☐ Reinstatement of Subscriber ☐ Addition of Dependent Prior ID # _____

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

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