

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
Email Address				
II. GROUP INFORMATION				
Employer / Group Name		Group No.	Division No.	Date of Hire Location No. (if applicable)
III. ENROLLMENT INFORMATION				
EFFECTIVE DATE OF ACTION (MM/DD/YYYY)				
QUALIFYING EVENT <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Return from Leave of Absence <input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> New Hire/Re-hire <input type="checkbox"/> Divorce <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Death of a Member				
ACTION CODE ADDITIONS TERMINATION STATUS CHANGE COBRA <i>Check one. Changes typically made on the first of the month.</i>				
<input type="checkbox"/> New Subscriber <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Remove Dependent <input type="checkbox"/> Transfer from Sublocation # _____ to # _____ <input type="checkbox"/> Addition of Dependent <input type="checkbox"/> Reinstatement List name in Section IV <input type="checkbox"/> Change Type of Coverage (Please indicate change, e.g. Individual to Family, in "Type of Coverage" section below.) Prior ID # _____				
TYPE OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Family <i>Check one.</i>				
IV. DEPENDENT INFORMATION *Group must have student rider.				
First Name	Last Name (if different)		Date of Birth (MM/DD/YYYY)	Relationship Check if student over 19*
V. DENTIST INFORMATION <i>List the dentist(s) you or your covered family members use.</i>				
Dentist(s) Last Name, First Name		City / Town		Patient(s) Last Name, First Name
VI. COORDINATION OF BENEFITS				
Are you or any of your dependents covered by another DENTAL plan? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If Yes, please complete the section below.</i>				
Policyholder Name (First, Last)		Policyholder I.D. No.		Group I.D. No.
Dental Insurance Company		Dental Insurance Address (Street, City, State, Zip)		
Employer Name (through which you/your dependents have coverage)				

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 _____

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.