altus dental™ | Altus Vision™

ENROLLMENT FORM

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

GROUP INFORMATION *To be completed by Human Resources or Benefit Administrator.*			
Employer / Group Name			Group No.
Dental Division No.	Vision 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
Check all that apply.

- ☐ Dental Preventive Plan
- ☐ Dental Low Plan
- ☐ Dental High Plan
- ☐ Vision

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
Check one.

ADDITIONS
- ☐ New Subscriber
- ☐ Add Dependent to Family
- ☐ Reinstatement

TERMINATION
- ☐ Remove Subscriber
- ☐ Remove Dependent
  List name in Section III

STATUS CHANGE
- ☐ Name / Address Change
- ☐ Transfer from Division #_____ to #_____
- ☐ Change Type of Coverage

COBRA
- ☐ 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	Enroll In: Vision
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

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 _____