altus dental™
Altus Dental Insurance Company, Inc.

Altus Dental Insurance Company, Inc.
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877-223-0588

ENROLLMENT FORM

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

☐ Open Enrollment   ☐ Marriage   ☐ Birth or Adoption   ☐ Return from Leave of Absence   ☐ Full-Time/Part-Time Status

☐ New Hire/Re-hire   ☐ Divorce   ☐ Workers' Compensation   ☐ Loss of Coverage   ☐ Death of a Member

ACTION CODE

Check one.
Changes typically made on the first of the month.

ADDITIONS	TERMINATION	STATUS CHANGE	COBRA
☐ New Subscriber	☐ Remove Subscriber	☐ Name / Address Change	☐ Reinstatement of Subscriber
☐ Add Dependent to Family	☐ Remove Dependent List name in Section IV	☐ Transfer from Sublocation # _____ to # _____	☐ Addition of Dependent Prior ID # _____
☐ Reinstatement		☐ Change Type of Coverage (Please indicate change, e.g. Individual to Family, in "Type of Coverage" section below.)	

TYPE OF COVERAGE

Check one.

☐ Individual   ☐ 2 Person   ☐ Family   **HIGH / LOW** *Check one.*   ☐ High   ☐ Low

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   *List the dentist(s) you or your covered family members use.*

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?	☐ No ☐ Yes *If Yes, please complete the section below.*

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

3T H/L
Rev0120 MM/YY - QTY [BUG]