

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
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 <u>ADDITIONS</u> <u>TERMINATION</u> <u>STATUS CHANGE</u> <u>COBRA</u> Check one. <input type="checkbox"/> New Subscriber <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Reinstatement of Subscriber Changes typically made <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 Prior on the first of the month. <input type="checkbox"/> Reinstatement <input type="checkbox"/> List name in Section IV <input type="checkbox"/> Change Type of Coverage (Please indicate change, ID # _____ e.g. Individual to Family, in "Type of Coverage" section below.)				
TYPE OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Family HIGH / LOW <input type="checkbox"/> High <input type="checkbox"/> Low Check one. Check one.				

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*
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

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.

	Date		Date
Employee Signature		Benefits Administrator Authorization	

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.