

ENROLLMENT FORM

Please print.

Employer Group Name <i>CITY OF PEABODY</i>		Altus Dental Group Number <i>1268-0001</i>		Date of Hire <i>N/A</i>	Location No. (if applicable) <i>N/A</i>																											
Social Security No. / Subscriber I.D. No.		Subscriber Name: First - Last																														
Date of Birth - MM / DD / YYYY		Street Address / P.O. Box No.		Email Address																												
Effective Date of Action:		Apt. No.	City	State	Zip																											
QUALIFYING EVENT <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> New Hire/Re-hire <input type="checkbox"/> Return From Leave of Absence <input type="checkbox"/> Marriage <input type="checkbox"/> Dependent's Loss of Coverage <input type="checkbox"/> Divorce <input type="checkbox"/> Full-Time / Part-Time Status <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Death of a Member			DEPENDENT INFORMATION																													
			First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																										
ACTION CODE (Check one. Changes must be made on the first of the month.)			DENTIST INFORMATION List the dentists you or your covered family members use: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Dentist(s) Last Name</td> <td style="width:33%;">First Name</td> <td style="width:33%;">City/Town</td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>			Dentist(s) Last Name	First Name	City/Town																								
Dentist(s) Last Name	First Name	City/Town																														
ADDITIONS: <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement			CORRECTIONS / OTHER REMARKS 																													
TERMINATION: <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student																																
STATUS CHANGE: <input type="checkbox"/> Change "Type of Coverage" Please indicate change (e.g. Individual to Family) in the section below. <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____			TYPE OF COVERAGE (Check one) <input type="checkbox"/> Individual <input type="checkbox"/> 2 Person <input type="checkbox"/> Family																													
COBRA: <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent — (From prior ID # _____)																																
COORDINATION OF BENEFITS																																
DENTAL — Are You or Any of Your Dependents Covered by <u>Another Dental</u> Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																																
Other Dental Insurance Name: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family																												
Other Dental Insurance Address: _____																																
Employer Name Through Which You /Your Dependents Have Other Insurance: _____																																
Group Policy No.		Policyholder Name		Policyholder ID No.																												
MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																																
Name of Medical Insurance Company / HMO: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family																												
Name of Health Plan / Type of Coverage: _____																																
Employer Name Through Which You / Your Dependents Have Other Insurance: _____																																
Group Policy No.		Policyholder Name		Policyholder ID No.																												

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Altus Dental. In addition, 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 _____