

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.		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	<u>ADDITIONS</u>	<u>TERMINATION</u>	<u>STATUS CHANGE</u>	<u>COBRA</u>	
<i>Check one. Changes typically made on the first of the month.</i>	New Subscriber	Remove Subscriber	Name / Address Change	Reinstatement of Subscriber	
	Add Dependent to Family	Remove Dependent	Transfer from Sublocation # _____ to # _____	Addition of Dependent Prior ID # _____	
	Reinstatement	List name in Section IV	Change Type of Coverage (Please indicate change, e.g. Individual to Family, in "Type of Coverage" section below.)		
TYPE OF COVERAGE	<input type="checkbox"/> Individual	<input type="checkbox"/> Family	RETIRED EMPLOYEE PLAN		
<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*
					<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.

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.