

Please print.

Employer Group Name		Altus Dental Group Number	Date of Hire	Location No. (if applicable)
Social Security No. / Subscriber ID No.	Subscriber Name: First - Last		Email Address	
Date of Birth - MM/DD/YYYY	Street Address / P.O. Box No.			
Effective Date of Action:	Apt. No.	City	State	Zip

QUALIFYING EVENT

Open Enrollment Workers' Compensation
 New Hire/Re-Hire Return From Leave of Absence
 Marriage Dependent's Loss of Coverage
 Divorce Full-Time/Part-Time Status
 Birth or Adoption 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.)

ADDITIONS:

New Subscriber
 Add Dependent to Family
 Reinstatement

TERMINATION:

Remove Subscriber
 Remove Dependent / Student

STATUS CHANGE:

Change "Type of Coverage"
 Please indicate (e.g. Individual to Family) under "Type of Coverage".
 Name / Address Change
 Transfer from Sublocation # _____ to # _____

COBRA:

Reinstatement of Subscriber
 Addition of Dependent — (From prior ID # _____)

DENTIST INFORMATION
List the dentists you or your covered family members use:

Dentist(s) Last Name	First Name	City/Town

CORRECTIONS / OTHER REMARKS

TYPE OF COVERAGE (Check one)	PLAN TYPE (Please check box if applicable.)
<input type="checkbox"/> Individual <input type="checkbox"/> Family	<input type="checkbox"/> High Option <input type="checkbox"/> Low Option

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? No Yes **If Yes, Please Complete the Section Below.**

Other Dental Insurance Name: _____ **Type of Coverage:** Individual Family

Other Dental Insurance Address: _____

Employer Name Through Which You/Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.
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MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? No Yes **If Yes, Please Complete the Section Below.**

Name of Medical Insurance Company / HMO: _____ **Type of Coverage:** Individual 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.
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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 _____
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