

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)				
<b>QUALIFYING EVENT</b> <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				
<b>ACTION CODE</b> ADDITIONS              TERMINATION              STATUS CHANGE              COBRA <i>Check one. Changes typically made on the first of the month.</i> <input type="checkbox"/> New Subscriber              Remove Subscriber <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Add Dependent to Family              Remove Dependent <input type="checkbox"/> Transfer from Sublocation # _____ to # _____ <input type="checkbox"/> Addition of Dependent <input type="checkbox"/> Reinstatement              List name in Section IV <input type="checkbox"/> Change Type of Coverage (Please indicate change, e.g. Individual to Family, in "Type of Coverage" section below.) <input type="checkbox"/> Prior ID # _____				
<b>TYPE OF COVERAGE</b> <input type="checkbox"/> Individual <input type="checkbox"/> 2 Person <input type="checkbox"/> Family <i>Check one.</i>				
IV. DEPENDENT INFORMATION <span style="float: right;">*Group must have student rider.</span>				
First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Check if student over 19*
				<input type="checkbox"/>
V. DENTIST INFORMATION <span style="float: right;"><i>List the dentist(s) you or your covered family members use.</i></span>				
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.