altusdental
Altus Dental Insurance Company, Inc.

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877-223-0588

ENROLLMENT FORM

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)

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

Check one.
Changes typically made on the first of the month.

ADDITIONS
☐ New Subscriber
☐ Add Dependent to Family
☐ Reinstatement

TERMINATION
☐ Remove Subscriber
☐ Remove Dependent
List name in Section IV

STATUS CHANGE
☐ Name / Address Change
☐ Transfer from Sublocation # _____ to # _____
☐ Change Type of Coverage (Please indicate change, e.g. Individual to Family, in "Type of Coverage" section below.)

COBRA
☐ Reinstatement of Subscriber
☐ Addition of Dependent
Prior ID # _____

TYPE OF COVERAGE ☐ Individual ☐ Family
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*
				☐
				☐
				☐
				☐
				☐

V. DENTIST INFORMATION

List the dentist(s) you or your covered family members use.

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? ☐ **No** ☐ **Yes** *If Yes, please complete the section below.*

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
Delta Dental of Rhode Island 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 1-800-843-3582.
Português (Portuguese): ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-800-843-3582.