

Altus Dental Insurance Company, Inc.
 PO Box 1557
 Providence, RI 02901-1557
 877-223-0588

GROUP INFORMATION <small>To be completed by Human Resources or Benefits Administrator.</small>		
Employer / Group Name		Group No.
Vision Division No.	Date of Hire	Location No. (if applicable)

VISION ONLY

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
Preferred Mobile Number		Preferred Email		

II. ENROLLMENT INFORMATION				
Effective Date of Action (MM/DD/YYYY)		TYPE OF COVERAGE <input type="checkbox"/> Vision		
QUALIFYING EVENT <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire/Re-hire	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce	<input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Return from Leave of Absence <input type="checkbox"/> Loss of Coverage	<input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Death of a Member
ACTION CODE <i>Check one.</i>	<u>ADDITIONS</u> <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement	<u>TERMINATION</u> <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent List name in Section III	<u>STATUS CHANGE</u> <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Division # _____ to # _____ <input type="checkbox"/> Change Type of Coverage	<u>COBRA</u> <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent Prior ID # _____

III. DEPENDENT INFORMATION				
First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Enroll in Vision
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

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
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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.