



ENROLLMENT FORM (ACTIVE EMPLOYEES)

P.O. Box 1557
Providence, RI 02901-1557
877-223-0588

Please print.

Employer Group Name CITY OF WORCESTER		Altus Dental Group Number 7696		Date of Hire	Location No. (if applicable)																					
Social Security No. / Subscriber I.D. No.		Subscriber Name: First - Last																								
Date of Birth - MM/DD/YYYY		Street Address / P.O. Box No.																								
Effective Date of Action:		Apt. No.	City	State	Zip																					
QUALIFYING EVENT			DEPENDENT INFORMATION																							
<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"/> Dependent's Loss of Coverage <input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Death of a Member			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"/>																					
ACTION CODE (Check one. Changes must be made on the first of the month.)																										
ADDITIONS:																										
<input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement																										
TERMINATION:																										
<input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student																										
STATUS CHANGE:																										
<input type="checkbox"/> Change "Type of Coverage" Please indicate change (e.g. Individual to Family) in the section below. <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____																										
COBRA:																										
<input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent — (From prior ID # _____)																										
			DENTIST INFORMATION List the dentists you or your covered family members use: <table border="1"> <thead> <tr> <th>Dentist(s) Last Name</th> <th>First Name</th> <th>City/Town</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			Dentist(s) Last Name	First Name	City/Town																		
Dentist(s) Last Name	First Name	City/Town																								
			CORRECTIONS / OTHER REMARKS 																							
			TYPE OF COVERAGE (Check one) <input type="checkbox"/> Individual <input type="checkbox"/> Family																							
COORDINATION OF BENEFITS																										
DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																										
Other Dental Insurance Name: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family																						
Other Dental Insurance Address: _____																										
Employer Name Through Which You/Your Dependents Have Other Insurance: _____																										
Group Policy No.		Policyholder Name		Policyholder ID No.																						
MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																										
Name of Medical Insurance Company/HMO: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> 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.																						

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 _____