altus dental™
Altus Dental Insurance Company, Inc.

Altus Dental Insurance Company, Inc.
PO Box 1557
Providence, RI 02901-1557
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)
TOWN OF NANTUCKET	2492			

III. ENROLLMENT INFORMATION

EFFECTIVE DATE OF ACTION (MM/DD/YYYY)

QUALIFYING EVENT

- ☐ Open Enrollment
- ☐ New Hire/Re-hire
- ☐ Marriage
- ☐ Divorce
- ☐ Birth or Adoption
- ☐ Workers' Compensation
- ☐ Return from Leave of Absence
- ☐ Loss of Coverage
- ☐ Full-Time/Part-Time Status
- ☐ 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

Check one.

☐ Individual ☐ Family

HIGH / LOW

Check one.

☐ High ☐ Low

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
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, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.

DENTAL EXPLAINED:

PLAN OPTIONS:

ALTUS DENTAL HIGH PLAN 2492-0002

Annual maximum limit: $1,500 per person/ per calendar year (resets every January for each member)	MEMBER COINSURANCE 20%, PLANS PAY (ALTUS) 80%	Annual Deductible: $50 per individual; $150 per family/ per year (You pay this up-front, out of pocket);
Please ask your Dentists for a pre-treatment estimate for services over $300. *ID cards are issued in employee's name. Everyone in your family will be covered under the same ID number*		
If your dentist doesn't accept insurance, you can still receive insurance coverage. You or your dentist would need to submit a reimbursement request to Altus Dental (see attached form and instructions).		
Example: You need a filling that costs $200. Your coinsurance for these services with this plan is 20%. • Your deductible is $50. You pay out of pocket. • On the remaining $150, coinsurance comes into play • Your coinsurance is 20%, so you pay 20% and your insurance pays 80% • 20% of $150 = $30 coinsurance for your fillings • Your total cost: $50 deductible +$30 coinsurance = $80		
• Preventative services 100% covered by Altus Dental (refer to plan summary) – this will not be deducted from your annual deductible of $1,500 per person/ per year; $50 deductible does not apply. • All other services 80% or 50% covered by Altus Dental (refer to plan summary) – will be deducted from your annual deductible of $1,500 per person/ per year; $50 deductible/ per person will apply;		

ALTUS DENTAL LOW PLAN 2492-0001

Annual maximum limit: $1,500 per person/ per calendar year (resets every January for each member)	MEMBER COINSURANCE 50%, PLANS PAY (ALTUS) 50%	Annual Deductible: $0 per individual (You pay this up-front, out of pocket)
Please ask your Dentists for a pre-treatment estimate for services over $300. *ID cards are issued in employee's name. Everyone in your family will be covered under the same ID number*		
If your dentist doesn't accept insurance, you can still receive insurance coverage. You or your dentist would need to submit a reimbursement request to Altus Dental (see attached form and instructions)		
Example: You need a filling that costs $200. Your coinsurance for these services with this plan is 50%. • Your deductible is $0. • On the $200, coinsurance comes into play • Your coinsurance is 50%, so you pay 50% and your insurance pays 50% • 50% of $200 = $100 coinsurance for your fillings • Your total cost: $0 deductible +$100 coinsurance = $100		
• Preventative services 100% covered by Altus Dental (refer to plan summary) – this will not be deducted from your annual deductible of $1,500 per person/ per year, No deductible. • All other services 50% covered by Altus Dental (refer to plan summary) – will be deducted from your annual deductible of $1,500 per person/ per year; No deductible;		