altusdental™ Altus Vision™ ENROLLMENT FORM

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

Employer Completes

GROUP INFORMATION *To be completed by Human Resources or Benefit Administrator.*

Employer / Group Name			Group No.
DCRSD			2895
Dental Division No.	**Vision Division No.**	**Date of Hire**	**Location No. (if applicable)**

I. SUBSCRIBER INFORMATION

Subscriber Name (First, Last)		Date of Birth (MM/DD/YYYY)	Social Security / I.D. #	
Jane Doe		05/03/1990	001-01-0001	
Street Address / P.O. Box No.	**Apt. No.**	**City**	**State**	**Zip**
12 Main St	8	Charlton	MA	01507
Preferred Mobile Number		**Preferred Email**		
774-000-0000		jdoe@gmail.com		

II. ENROLLMENT INFORMATION

Effective Date of Action (MM/DD/YYYY): 08/25/2025

TYPE OF COVERAGE *Check all that apply.*
- [x] Dental Low Plan
- [ ] Dental High Plan
- [x] Vision

QUALIFYING EVENT
- [ ] Open Enrollment
- [x] 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.*

ADDITIONS
- [x] New Subscriber
- [ ] Add Dependent to Family
- [ ] Reinstatement

TERMINATION
- [ ] Remove Subscriber
- [ ] Remove Dependent *List name in Section III*

STATUS CHANGE
- [ ] Name / Address Change
- [ ] Transfer from Division #_____ to #_____
- [ ] Change Type of Coverage

COBRA
- [ ] Reinstatement of Subscriber
- [ ] Addition of Dependent Prior ID # _____

III. DEPENDENT INFORMATION

First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Enroll In: Dental	Enroll In: Vision
Marc		03/25/1991	spouse	☒	☒
Sarah		05/26/2015	daughter	☒	☒
				☐	☐
				☐	☐
				☐	☐
				☐	☐

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.

Jane Doe — Employee Signature

8/25/25 — 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.