altus dental™
Altus Dental Insurance Company, Inc.

ENROLLMENT FORM

Christie Student Health
Group #6680-0002

Personal Information Please fill out this form entirely. Incomplete forms will delay your application.

New England Conservatory	Social Security Number	Date of Birth **(MM/DD/YYYY)**	
First Name	Last Name		
Street Address / P.O. Box Number	City	State	Zip Code
Email address	Telephone number		

Coverage Type & Premium Rates Please select a coverage type (Individual or Family). Rates effective 08/25/2015 - 08/24/2016.

ANNUAL RATE

☐ Student $353.40 ☐ Student/Spouse $720.00 ☐ Student/Child $1,447.44 ☐ Student/Family $1,628.64

Your coverage does not automatically renew at the end of your coverage period.

Family Information If you've selected Family Coverage, fill in the appropriate information:

Spouse_____/_____ Child_____/_____
last, first *date of birth* *last, first* *date of birth*

Child_____/_____ Child_____/_____
last, first *date of birth* *last, first* *date of birth*

Coordination of Benefits (Additional Dental and Medical Coverage)

Are you or any of your family members covered by another dental plan? ☐ YES ☐ NO Is this an Individual ☐ or Family ☐ Plan? (Check one.)

Other Dental Insurance Name:_____ Other Dental Insurance Address:_____

Policyholder Name:_____ Policy Number:_____

Are you or any of your family members covered by a medical plan? ☐ YES ☐ NO Is this an Individual ☐ or Family ☐ Plan? (Check one.)

Other Medical Insurance Name:_____ Other Medical Insurance Address:_____

Policyholder Name:_____ Policy Number:_____

Method of Payment (See back for details.)

Please check ☑ a payment type and fill in the appropriate information. All premium payments are to be paid annually.

☐ **A. Direct Withdrawal from Bank Account:** **Type:** ☐ **Checking** ☐ **Savings**

Name on Bank Account:_____

Bank Name:_____ Bank Address:_____

Routing Number:_____ Bank Account Number:_____

☐ **B. Credit Card:**

Name: (exactly as it appears on Credit Card)_____

Credit Card Type: ☐ MasterCard ☐ Visa Credit Card Number:_____ Expiration Date:_____ (MM/YYYY)

Authorizing Signature:

I certify that all information is true and correct to the best of my knowledge. I understand that the start date and cancellation date of my insurance coverage will be determined by Altus Dental. If I have selected Payment Method A or B, I authorize Altus Dental to withdraw funds from my bank account or charge my credit card no more than ten (10) days prior to the start of coverage, and on a monthly/quarterly basis thereafter. I understand that if funds/available credit balances are not available or payment is not otherwise timely made, I will no longer be eligible for coverage. I have read and understand the information on both the front and back of this form.

Your signature (Form will not be processed without signature.) **Date**

Please send this form to: Altus Dental, PO Box 1557, Providence, RI 02901-1557
Email: enrollment@altusdental.com
Fax: 401-457-7240

Form Number: 100104-3-1

altus dental™
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New England Conservatory

P.O. BOX 1557
Providence, RI 02901-1557
1-877-223-0588
www.altusdental.com

Please read the following information regarding the plan's eligibility, coverage and payment guidelines.

Eligibility Information

You must be a New England Conservatory Student to qualify and remain eligible for coverage.

Coverage Type and Premium

Altus Dental offers both Individual and Family Coverage. Rates are guaranteed for the entire coverage period.

Enrollment and payment of premium is not a guarantee of claim payment. To be covered, services must be dentally necessary and in accordance with Altus Dental's treatment guidelines. All services must be performed in a dental office and the patient must be covered by an Altus Dental contract on the day services are completed. There are no refunds of premium dollars for this coverage.

Renewal of Coverage

Your coverage will not automatically renew at the end of your coverage period. Your coverage period is from August 25, 2015 until August 24, 2016, unless otherwise noted.

Family Information

If you are electing Family Coverage, please provide the first name, last name and date of birth for each family member to be covered by this plan. List your spouse first (if applicable) and then list your children. Dependent children are covered up until the end of the month that they turn age 19.

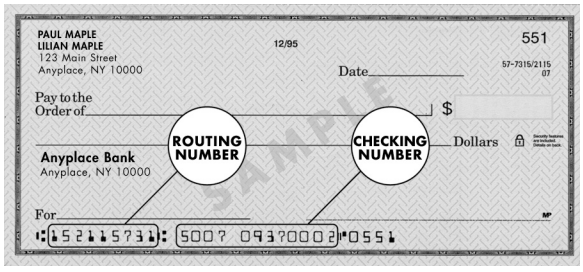
Coordination of Benefits (Additional Medical and Dental Coverage)

Please provide Altus Dental with any other medical or dental plan that covers you or your family member(s).

Method of Payment

This is a pre-paid dental insurance plan. Altus Dental offers two convenient payment types.

A.) Direct Withdrawal from Bank Account – Funds will be withdrawn no more than ten (10) days prior to the start of coverage. Please use this sample check as a guide when selecting direct withdrawal from your checking account. **Please Note: Transactions that are returned for insufficient funds are subject to a $25 processing fee.**



B.) Credit Card – You may opt for Altus Dental to charge your credit card. Your credit card will be charged no more than ten (10) days prior to the start of coverage. **Please Note: Transactions that are declined are subject to a $25 processing fee.**

Authorizing Statement

Please read the authorizing statement on the front of this enrollment form, and sign and date it. Altus Dental cannot process forms without an authorizing signature. You will receive your Subscriber ID card and Certificate of Coverage approximately 15 days before your coverage begins.

Please send this form to: Altus Dental, PO Box 1557, Providence, RI 02901-1557
Email: enrollment@altusdental.com
Fax: 401-457-7240