Corporate Office
135 Wood Road
Braintree, MA 02184
781.848.4950

New Case Submission Checklist

Altus for One Dental Plan

Available to Sole Proprietors and
Firms with 2 or More Employees

To ensure your application is processed as quickly and accurately as possible, follow these steps:

1	**Sole Proprietor** or **Employer** completes **HSA Insurance Membership Application.**	☐
2	**Sole Proprietor** or **Employer** completes **Employer Enrollment Form.**	☐
3	**Sole Proprietor** provides copy of most recent **Schedule C. Employer** (2 or more employees) provides **WR-1.** New Businesses, the owner must provide copies of D.B.A. certificate, Business License, Articles of Incorporation or other proof deemed appropriate.	☐
4	**Sole Proprietor** or each **employee** must complete individual **Enrollment Form.**	☐
5	**Employee waiving dental** coverage must complete a **Waiver Form** with **Proof of Coverage.**	☐
6	Pay your **first premium, $5 monthly service fee and $25 annual membership fee**: • Pay over the phone: (781) 228-2222. Payment Confirmation #:________________________ -or- • Complete Electronic Payment Request Form -or- • Enclose check payable to HSA *(Receipt of payment does not guarantee coverage. HSA must receive completed enrollment materials by the carrier deadline)*	☐
7	Enclose Annual Membership Fee of $25 (Payable to HSA) **-or-** If enrolling through an **Association or Chamber of Commerce, please indicate name of Association or Chamber** ____ * If not already a member of a participating Association or Chamber of Commerce, additional requirements may apply such as completing a membership application and paying dues.	☐
8	Send all required documents (including this checklist) to: **Corporate Office** 135 Wood Road Braintree, MA 02184 Sales Rep: Contact Info:	☐

PLEASE NOTE: Complete applications and premium payment for new business must be received by HSA at least 5 business days prior to the requested effective date.

All coverage will be effective on the 1st day of the month. Keep a copy of your application as your temporary ID. Once your enrollment have been approved and processed, you will receive a member confirmation by mail with your account number. Your permanent ID cards will be issued to you directly from the carrier. **Permanent ID cards generally take 7-10 business days from date your enrollment was approved and processed.**

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Membership Application

Please complete each section of this application. Failure to do so could delay enrollment.

Employer information

Employer name____ Date business established (Mo./Yr.) _____/_______

Employer address ____

City ____State ________________ Zip ____________________

Owner/principal contact name (first and last) _______________________________ Title____________________________

Business Phone ______________________ Cell phone _______________________ Fax ______________________________

Email ____ Website ___________________________________

Billing address ____

City____State _______________ Zip ____________________

Type of business ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ LLC ❑ Other: ____________________________

Nature of business: ____

Employer tax ID# ____ SIC code_______________________

Do you regularly employ at least one individual that is not an owner and/or the spouse of an owner? ❑Yes ❑ No

Number of full-time employees (30 hours or more per week; including owner) ___________

Number of part-time employees (less than 30 hours per week) ____________

Quote # (from Group Proposal) _______________________________________

Certification and Disclosures

1. The company named above is a bona fide business and not in operation for the sole purpose of obtaining health insurance.
2. All enrollees are actively working for financial compensation and are covered by Worker's Compensation as required by law.
3. Premium payments are due on the 25th of each month for coverage effective the 1st of the next month.
4. Insurance coverage is subject to cancellation if payments are not received by the 1st of the month.
5. Payments not received by the 10th of the month are subject to a late fee, currently $25.
6. Payments not received by the 20th of the month are subject to a pending termination fee, currently $50.
7. Reinstatement of coverage terminated due to non-payment of premium is at the sole discretion of the carrier. Reinstatements are subject to a reinstatement fee, currently $50.
8. Checks returned for insufficient funds or other reasons will be charged a bad check fee, currently $20.
9. Member firms must maintain good standing in their respective Business Association or Chamber of Commerce to participate in the group insurance programs offered through HSA Insurance.
10. HSA Insurance charges a monthly service fee per account.

HSA Insurance is a billing and enrollment agent and is not responsible for payment of claims on your behalf.
I certify that the information on this form is true and complete, that I understand and agree to the above administrative requirements, and that I have the legal authority to sign on the company's behalf.

Signature ____ Title ______________________________ Date ___________

Broker name (if applicable) ____
Address ____
City ____ State ________________________ ZIP ______________

For office use only
Account representative ____

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Altus for One
Employer Enrollment Form

Company Name:
Address:

Desired Effective Date:
(must be 1st of month)

Contact name:

Phone:

Email:

Plan Selection

☐ Altus for One

ELIGIBILITY & PARTICIPATION REQUIREMENT

ELIGIBLE COMPANIES: Self employed and firms with 2 or more full time employees that maintains a membership with HSA
ELIGIBLE EMPLOYEES: All full-time employees working at least 30 hours per week
WAIVER: EE's covered on a spouse's family dental plan can be excluded; a Waiver Form must be completed
PARTICIPATION REQ: 70% of the eligible employees must be enrolled and must remain on the plan for a minimum of one year
EMPLOYER CONTRIBUTION: The employer must contribute at least 50% of the EE's premium
NEW HIRES: All eligible EEs can be enrolled within 30 days of hire or within time frame consistent with company new hire probation policy

ENROLLMENT INFORMATION

SIC Code (4 digits) [________]
Nature of business:

Employer Contribution
(minimum 50%)

Type of Business
☐ Sole Proprietor
☐ Partnership
☐ Corporation

Eligibility Waiting Period*
None___ 1 Months___ 2 Months___ 3 Months___ 4 Months___ 5 Months___

***Definition:** The period from the date of hire to the time a new employee is eligible to be added to the company health plan.

Total # of employees (including owners) _____
Subtract EEs covered by spouse's dental plan _____
Total # of Eligible EEs _____

The Effective date of coverage for new eligible employees is:
☐ The 1st of the month following satisfaction of waiting period
☐ The day the waiting period has been satisfied (i.e. one month from date of hire)

MONTHLY PREMIUM CALCULATION

ALTUS DENTAL					
Type of coverage	# of Elig EEs	X	Monthly Rate*	=	Premium
EE Only		x		=	
EE & Spouse		x		=	
EE & Child		x		=	
Full Family		x		=	
Service Fee	1	x	$5.00	=	$5.00
TOTAL COMPANY PREMIUM				=	
* Enter rates for your plan					

I CERTIFY THAT THE INFORMATION ON THIS APPLICATION IS TRUE AND COMPLETE

Signature (Authorized Employer Representative)	**Title**	**Date**

Broker Name (If Applicable)	**Agency Name, Address**	**Phone**	**Account Rep**

altus dental™
Altus Dental Insurance Company, Inc.

ENROLLMENT FORM

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

Please print. Complete form to ensure enrollment.

Employer Group Name	Altus Dental Group Number	Date of Hire	Location No. (if applicable)
	| | | | — | | | |	/ /	

Social Security No. / Subscriber I.D. No.	Subscriber Name: First (8 Characters) Last (16 Characters)

Date of Birth	Street Address / P.O. Box No.
/ /	

Effective Date of Action:	Apt. No.	City	State	Zip
/ /				

QUALIFYING EVENT

- _____ Open Enrollment
- _____ New Hire/Re-hire
- _____ Marriage
- _____ Divorce
- _____ Birth or Adoption
- _____ Workers Compensation
- _____ Family Medical or Disability Leave
- _____ Spouse's Loss of Coverage
- _____ Full Time/Part Time Status
- _____ Death of a Member

ACTION CODE (Check One) *(Changes must be made on the first of the month)*

Explain in "Other Remarks" if necessary.

ADDITIONS:

- _____ New Subscriber
- _____ Add Dependent to Family
- _____ Reinstatement

TERMINATION:

- _____ Remove Subscriber
- _____ Remove Dependent / Student

STATUS CHANGE:

- _____ Change "Type of Coverage"
  Please indicate change (e.g. Individual to Family) in the section below.
- _____ Name / Address Change
- _____ Transfer from Sublocation #_______________ to #_______________

COBRA:

- _____ Reinstatement of Subscriber
- _____ Addition of Dependent — (From prior ID # ____________________)

DEPENDENT INFORMATION

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Student Rider (over age 19)
Spouse		Please check box below if full-time student.
Children		☐
		☐
		☐
		☐
		☐
		☐

DENTIST INFORMATION

List the dentists you or your covered family members use:

Dentist(s) Last Name	First Name	City/Town

CORRECTIONS / OTHER REMARKS

(Please Explain)

Type of Coverage (Check One) ❑ Individual ❑ Individual & Spouse ❑ Family ❑ Individual & Child/Children

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? ❑ No ❑ Yes If Yes, Please Complete the Section Below.

Other Dental Insurance Name: ____________ Type of Coverage: ❑ Individual ❑ Family

Other Dental Insurance Address: ____________

Employer Name Through Which You/Your Dependents Have Other Insurance: ____________

Group Policy No.	Policy Holder Name	Policy Holder ID No.

MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? ❑ No ❑ Yes If Yes, Please Complete the Section Below.

Name of Medical Insurance Company/HMO: ____________ Type of Coverage: ❑ Individual ❑ Family

Name of Health Plan/Type of Coverage: ____________

Employer Name Through Which You/Your Dependents Have Other Insurance: ____________

Group Policy No.	Policy Holder Name	Policy Holder 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 ____________

SUBMIT TO ALTUS DENTAL

GCIU 1082M

One Person Dental Plan

Waiver of Coverage Form

Company Name: ____

Employee Name: __________________________________ Date of Birth: _________________

Reasons for Waiving Coverage (check one):

____ Covered through parent's Dental plan

____ Covered through spouse's employer's Dental plan

Employer name ____

Dental Carrier ____

Must provide copy of dental I.D. card or copy of coverage certificate

_____ Other ____

____

____

Signature of the Employee Date

This form may be duplicated

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Electronic Payment Request Form

New Client? Pressed for time? Call (781) 228-2222 (8:30am-5:00pm, M-F) to quickly set up electronic payments. Just have your bank account and routing numbers ready. Or, complete this form:

Client Information:

Client Name: ______________________________ Client Email: ______________________

New Client: Quote number and/or Application ID: ______________________________

Current Client: 6 Digit HSA Account number: ____________

Select payment type:

- ☐ **Recommended for new clients:** Withdraw both first month payment and recurring monthly payments
- ☐ First month payment only

If requesting recurring monthly payments, select date for withdrawal.

☐ 15th of the month ☐ 24th of the month

All outstanding balances owed, including fees, will be transferred at that time.

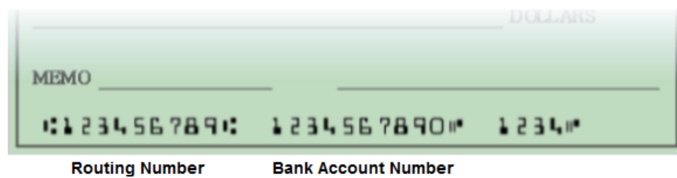
Bank Information:

Bank Name: __________________________ City: ____________ State ___ Zip: _______

Name on Account: ____

Routing Number: ____________________ Bank Account Number: ______________________

Account Type: ☐ Checking ☐ Savings



Authorization:

I (we) hereby authorize HSA Insurance to initiate debit entries for my (our) checking account and the depository named above, hereinafter called DEPOSITORY, to debit the same to such account. This authorization is to remain in full force and effect until HSA Insurance has received written notification from me (us) of its termination in such time and in such manner as to afford HSA and DEPOSITORY a reasonable opportunity to act on it. Note: all written debit authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

Authorized Signer ________________________ ____________________________

Sign Name Print Name and Title

Date: ________________ Client Telephone: ______________________________

Return Form

Please fax or secure email the completed form to: (781) 848-7020 or enrollment@hsainsurance.com
For changes to existing bank information, please contact Customer Service: (781) 228-2222.