



ENROLLMENT FORM

Plumbers Union Local 12 Welfare Fund

Personal Information

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

Plumbers Union Local 12 Welfare Fund		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 thru 12/31/10.

Monthly Premium (For bank and credit card withdrawals only.)	Quarterly Premium
___ Individual \$43.40 ___ Family \$159.82	___ Individual \$130.20 ___ Family \$479.46

Your coverage is automatically renewed at the end of your coverage period unless you notify us in writing that you wish to cancel coverage.

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

Spouse _____ / _____ <i>first name only date of birth</i>	Child _____ / _____ <i>first name only date of birth</i>
Child _____ / _____ <i>first name only date of birth</i>	Child _____ / _____ <i>first name only date of birth</i>

Coverage Action

Please select one: ___ New Enrollee ___ Add Family Member ___ End Coverage ___ Change Name/Address/Billing

Please select one of the following reasons when changing family coverage: ___ Marriage ___ Birth/Adoption ___ Divorce ___ Loss of Coverage

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, select the frequency of payment and fill in the appropriate information.

A. Direct Withdrawal from Bank Account: Quarterly Monthly Type: ___ Checking ___ Savings

Name on Bank Account: _____

Bank Name: _____ Bank Address: _____

Routing Number: _____ Bank Account Number: _____

B. Credit Card: Quarterly Monthly

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

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

C. Payment by Check: Add an additional \$2.00 to the premium total to cover the check processing fee.
Only quarterly payments may be made by check. We must have your check to process your application. Quarterly premium coupons will be sent to you once you're enrolled.

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

Eligibility Information

You must be an active Plumber's Union Local 12 Welfare Fund member or Medicare-eligible individual to qualify and remain eligible for coverage. If you suspend your membership with this association, your dental coverage is subject to termination.

Coverage Type and Premium

Altus Dental offers both Individual and Family Coverage. Enrollment in this program is on an annual basis. Rates are guaranteed for the entire coverage period. Prior to the end of a coverage period, Altus Dental will mail a notification to you indicating any change in rates.

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 is automatically renewed at the end of your coverage period. Your coverage period is from your coverage start date until the end of the calendar year, unless otherwise noted.

If you choose to end your coverage, you must notify us in writing. Cancellation of coverage is effective on the last day of your most recent payment period, depending on the frequency of your payment (e.g. monthly, quarterly). **Please Note: If you cancel coverage, you must wait 12 months to reapply. If your new application is accepted, your coverage will begin on January 1 of the following year. Altus Dental reserves the right to cancel coverage after appropriate notification due to non-payment of premium.**

Family Information

If you are electing Family Coverage, please provide the first 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. Dependent children who are full-time students over age 19 are covered as long as they stay in school or up until the end of the month in which they turn age 23.

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).

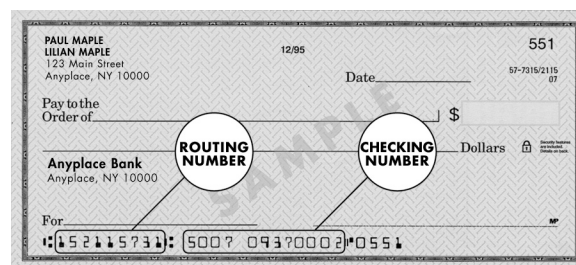
Method of Payment

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

A.) Direct Withdrawal from Bank Account – You may elect to have funds withdrawn from your bank account either quarterly or monthly. Funds will be withdrawn no more than ten (10) days prior to the start of coverage, and on a monthly/quarterly basis thereafter. Please use this sample check as a guide when selecting direct withdrawal from your checking account. **Please Note: Transaction 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 either monthly or quarterly. Your credit card will be charged no more than ten (10) days prior to the start of coverage, and on a monthly/quarterly basis thereafter. **Please Note: Transaction that are declined are subject to a \$25 processing fee.**

C.) Payment by Check – Only quarterly payments may be made by check. Quarterly premium coupons will be sent to you once you're enrolled. Altus Dental will not send you a monthly bill. **Please Note: Each check will incur an additional \$2.00 check processing fee. Returned checks are subject to a \$25 processing fee.**



Authorizing Statement

Please read the authorizing statement on the front of this enrollment form, and sign/date it. Altus Dental cannot process forms without an authorizing signature. Check payments must accompany Altus Dental's copy of the form to be processed. You will receive your Subscriber ID card and Certificate of Coverage approximately 15 days before your coverage begins.

Please mail this form and your payment to Altus Dental, PO Box 1557, Providence, RI 02901-1557.