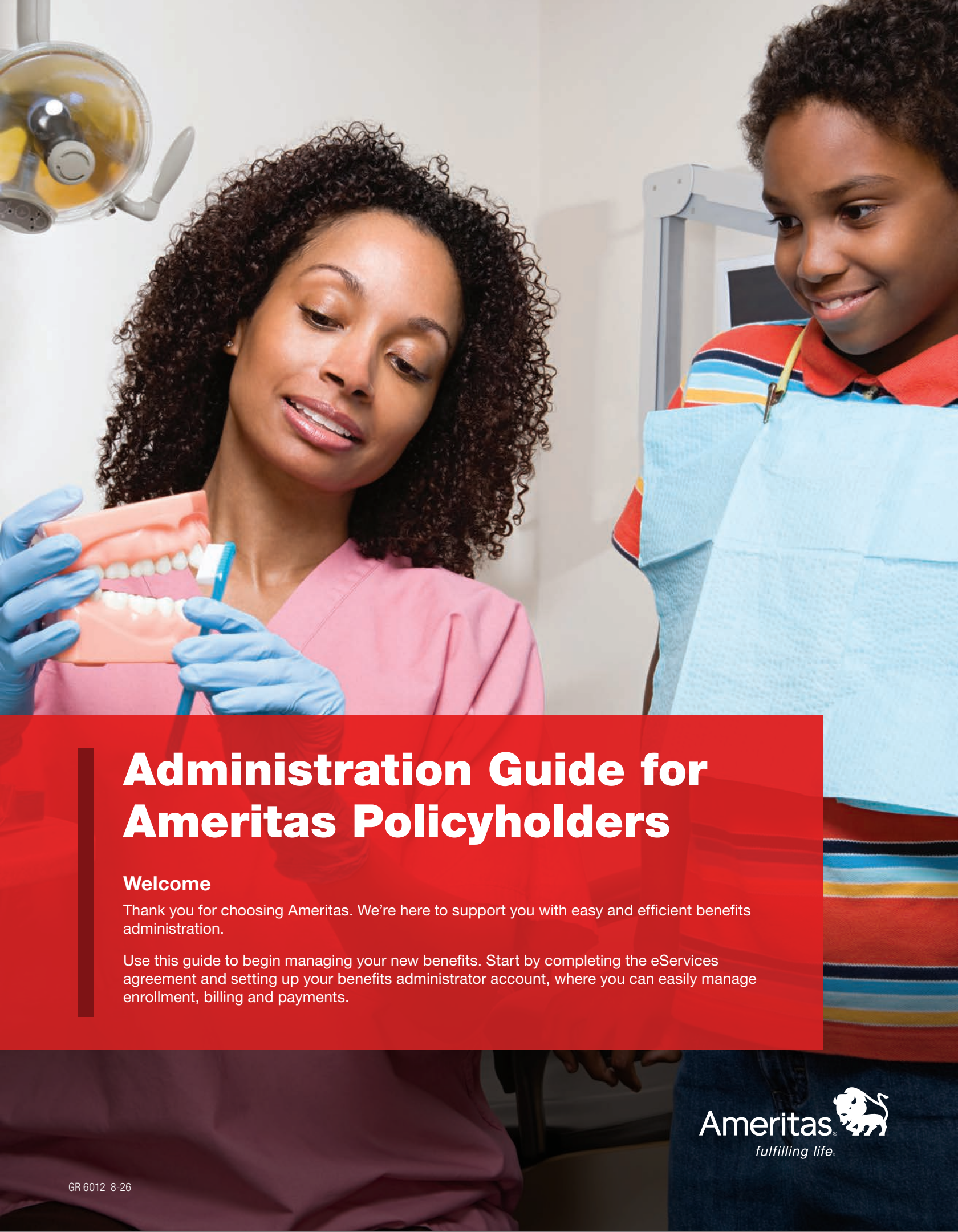


Administration Guide for Ameritas Policyholders

Welcome

Thank you for choosing Ameritas. We're here to support you with easy and efficient benefits administration.

Use this guide to begin managing your new benefits. Start by completing the eServices agreement and setting up your benefits administrator account, where you can easily manage enrollment, billing and payments.

Ameritas
fulfilling life.

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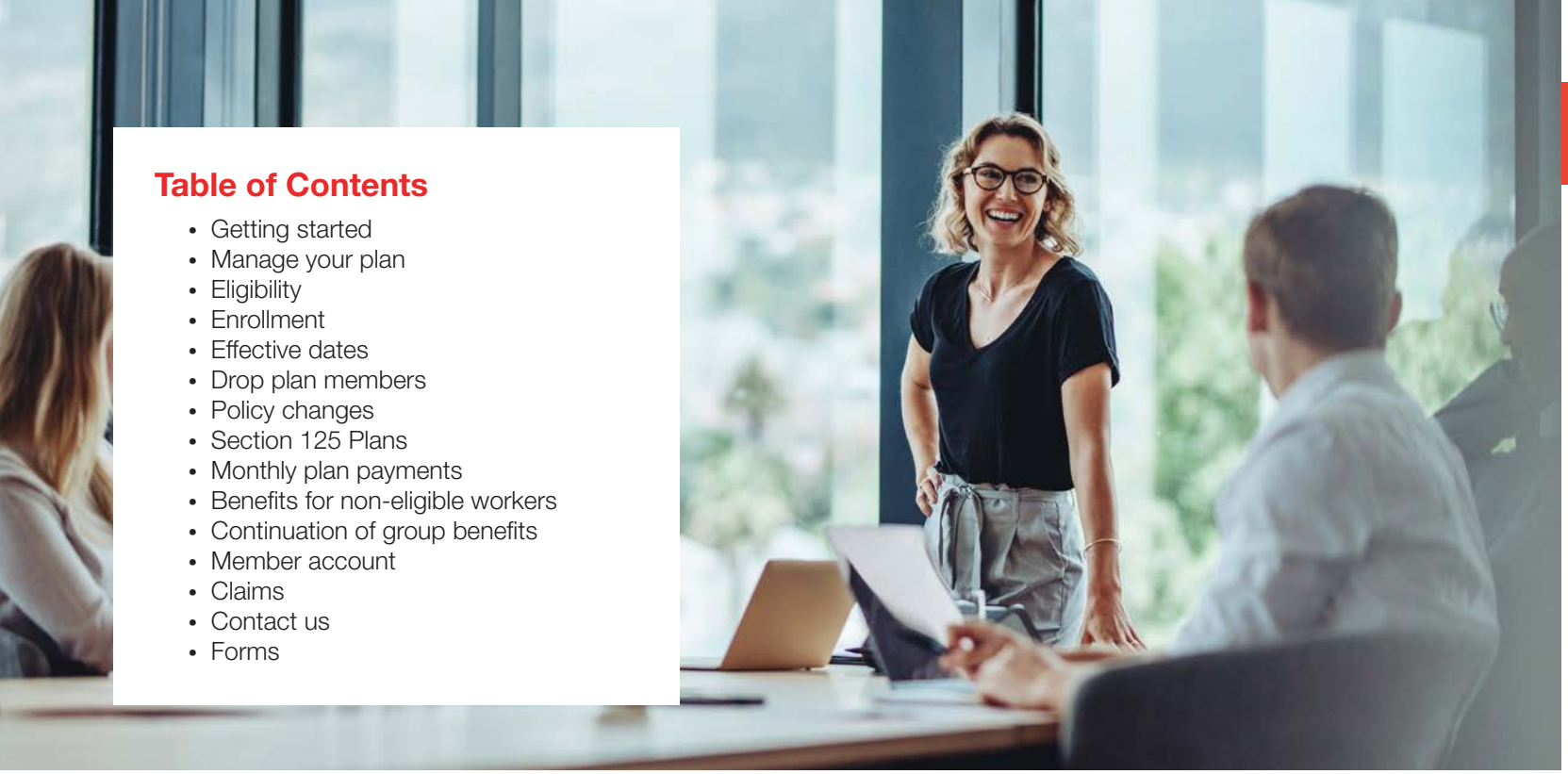


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Getting Started

After you receive the welcome email from Ameritas with important information about your policy, complete the following steps:

1. **Review your certificate(s) and master policy**. Plan rates are listed in your master policy under 9050 – Table of Monthly Premiums.

2. **Distribute the GLB Privacy Notice to plan participants.** English and Spanish versions are included in this guide and at ameritas.com/about/privacy under Dental, Vision and Hearing Care.

3. **Create your account.** Your benefits administrator account provides access to eServices — online services that help you manage enrollment, billing and payments electronically.

To get full access to eServices:

- Access your authorization ID.
  - If your policy was sold with eCert, you'll receive an authorization ID automatically and access to your certificate(s) and policy.
  - If your policy does not include eCert, an authorization ID will be emailed to you after you complete the eServices agreement.
- Complete and submit the eServices agreement, which can be found at ameritas.com/businesses/dental-vision.
- Visit ameritas.com/sign-in, Business Accounts and select Benefits Administrator Sign In under Dental, Vision & Hearing, and click Register Now.
- Create your benefits administrator account using the authorization ID and instructions emailed to you from securityadmin@employeebenefitservice.com.

For help with account setup or adding users, scan the QR code to view the registration guide video or call 800-659-2223.

Manage Your Plan

eServices

To access your account, visit ameritas.com/sign-in, Business Accounts and select Benefits Administrator Sign In under Dental, Vision & Hearing. Once signed in, you can use eServices to manage your policy in several ways.

Certificate, policy (eCert)

- View or print certificates, policies and ID cards
- Distribute certificates electronically or post them on your benefits intranet
- Allow employees to view and print their own certificates
- Access the most current plan documents and updates

Enrollment (eEnroll)

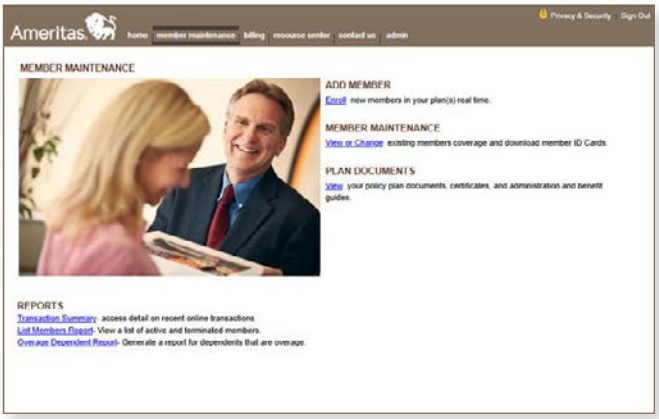
- Enroll, change or drop employee coverage in real time
- View coverage status, effective dates and dependent coverage levels

Billing and EFT (eBill)

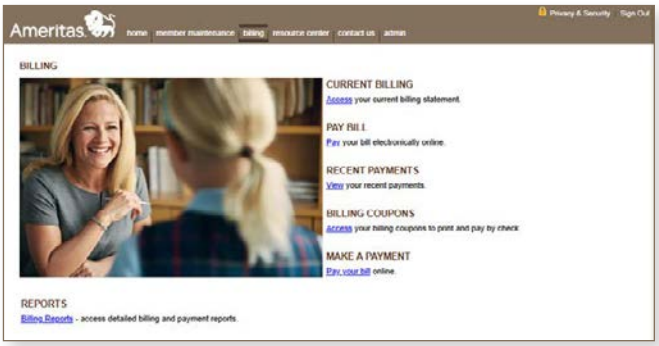
- Request and pay bills online
- Update member and dependent information before payment
- View or print detailed billing and adjustment reports
- Access up to one year of billing history and premium information

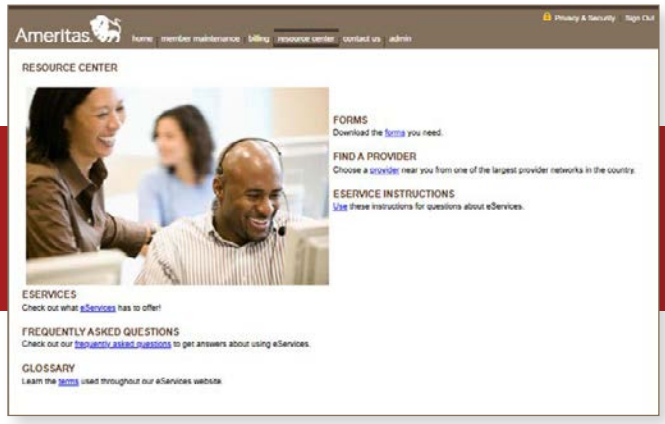
EDF, an electronic enrollment file process, is also available to qualifying groups.

Access the Member Maintenance page for eCert and eEnroll.



Access the Billing page for eBill.





Step-by-step guidance for using eServices can be found in the eServices Guide located on the Resource Center page.

Eligibility for plan enrollment

Employee eligibility

Eligibility requirements are defined in your policy under 9070 – Conditions for Insurance Coverage. The eligibility period, also known as the new hire waiting period, is satisfied when the member meets the policy's requirements; for example, working at least 30 hours per week. When the eligibility period is satisfied, the member's coverage becomes effective.

Dependent eligibility

The member's eligible dependents include:

- Member's spouse (or domestic partner if this coverage is elected)
- Each child under the age defined in your policy (see 9060 – Definitions) who is the member's or member's spouse's legal responsibility, including:
  - Natural born children
  - Adopted children, eligible from the date of placement for adoption
  - Children covered under a Qualified Medical Child Support Order as defined by applicable federal and state laws
- Each child who is:
  - A full-time student at an accredited school or college; and
  - Primarily dependent on the member or member's spouse for support and maintenance

A divorced spouse is not eligible, but a spouse who is separated from the member is eligible.

Over-age child dependents

To avoid claim delays or denials, notify Ameritas when a child dependent reaches the maximum eligible age. You can monitor this by running an over-age dependent report and updating coverage in your benefits administrator account. Dependent age limits, including limitations for full-time students are outlined in 9060 – Definitions of your policy.

Please review your policy for specific eligibility requirements.
For questions, call 800-659-2223.





Enroll plan members, dependents

Instructions for adding or updating member or dependent coverage are available in the **eServices Guide**, located in the Resource Center when signed in to your **benefits administrator account**.

If you have not yet set up your account, have your employee fill out an Ameritas enrollment/change/waiver form available in this guide or at **ameritas.com/employee-benefits/forms**. Ameritas retains the original enrollment form, so please make a copy for your records before submitting it.

Mail, fax or email enrollment forms to:
Ameritas Group Administration
P.O. Box 82669
Lincoln, NE 68501-2669
Fax: 402-467-7338
Email: group_assistants@ameritas.com

For dependents, note the following on the form:

- Reason for the change
- Date the dependent qualified for coverage
- And/or date the dependent coverage should end

Incomplete information or missing signatures may delay enrollment. In addition, the employee needs to elect coverage within 31 days of becoming eligible to avoid possible late entrant limitations. See 9060 – Definitions in your policy to determine if late entrant provisions apply.

The member's ID card and/or certificate of coverage will be available after the member is enrolled. Once the member's first claim is submitted and paid, members can opt to go paperless and receive their Explanation of Benefits (EOB) statements online in their **member account**.

Same employer spouse provision

This applies to a married couple who are both employed by your company and have eligible dependent children. It allows for one spouse to carry the employee coverage and the other spouse to be covered as a dependent along with the children. See 9070 – Conditions for Insurance Coverage in your policy to determine if this is included in your plan.

Total disability

This describes a dependent who is continuously incapable of self-sustaining employment because of mental or physical handicap and chiefly dependent upon the member for support and maintenance.

Dependent exceptions

Ameritas may make exceptions for dependents who are not natural born, adopted or stepchildren of the member, but who do meet the dependent age requirement in your policy under 9060 – Definitions. Exceptions may include when the:

- Member has legal guardianship of the dependent
- Dependent is covered by the member's medical carrier
- Member legally claims the dependent at tax time

Effective dates

The effective date for members and their covered dependents is based on the following. The eligibility period also is known as the new hire waiting period. Note: Some policies do not allow employees to waive coverage for themselves or their dependents.

If the enrollment form is signed	The member's effective date is*
On or before the eligibility period is satisfied	The date the eligibility period is satisfied
Within 31 days after the eligibility period is satisfied	The date the enrollment form is signed
Over 31 days after the eligibility period is satisfied	The date the enrollment form is signed**

**Some policies are written with first-of-the-month effective dates. Coverage for these policies becomes effective on the first of the month following the date the member becomes eligible.*

***Check your policy to see if late entrant limitations apply.*

Sample of a 90-day eligibility period



Exceptions

If employment is the basis for plan participation, an employee needs to be in active service on the date the insurance, or any increase in insurance, takes effect. Otherwise, the insurance will not take effect until the day the employee returns to full-time active service.

Reinstatement or rehires

If employment is the basis for plan participation, a member whose eligibility terminates and is re-established may need to complete a new eligibility period. However, if the person is rehired within 12 months from the original termination date, there's no waiting period. On the enrollment/change form, include the date of rehire after the Rehire check box.

Drop plan members, dependents

Instructions for dropping member or dependent coverage are available in the eServices Guide, located on the Resource Center page when signed in to your benefits administrator account.

Outside of your benefits administrator account, you can:

- List terminated members on page 1 of the premium statement, and note the last day worked
- Draw a line under the member's name on the itemized listing, and note the last day worked
- Call our administration and billing department toll free at 800-659-2223
- Complete an enrollment form, note the last day worked, and mail or fax it to Ameritas Group Administration

Please note that coverage ends on the date the member ceases to be an eligible member, unless your group policy contains an end-of-month provision. The member's termination date excludes accrued vacation time or similar benefits. There's no refund when termination occurs in the middle of a policy month, so the premium should be paid for the full month.

Member terminations should be reported as quickly as possible. Without current member eligibility information, Ameritas may inadvertently pay claims for expenses incurred after the member or dependent's termination date. If this happens, Ameritas may require additional premium from your company to cover it. Refer to 9050 – Simplified Accounting in your policy for more information.

Some members may be eligible for a continuation of coverage through COBRA. Or, you can offer them Ameritas individual dental or vision plans. See Benefits for non-eligible workers for more information.

Policy changes

Policy changes you may need to make include:

- Company name change
- Eligibility period change
- Number of weekly work hours members need to qualify for coverage
- Adding additional Ameritas benefits, such as dental, vision, LASIK or hearing

To make policy changes, please inform your Ameritas representative or your benefits broker, and send us a letter outlining your request. Some updates may require additional underwriting and impact your rates.

Your letter should:

- Outline your desired plan change
- Include your requested effective date
- Be submitted in writing on your company letterhead
- Be signed by a person authorized to represent your company
- Be mailed, faxed or emailed to Ameritas Group Administration

Section 125 Plans

Details about Section 125 requirements can be found under IRS 26 U.S. Code § 125 and supporting treasury regulations. Please consult your tax advisor for more information and advice regarding cafeteria plans.

Section 125 of the IRS code allows employees to purchase benefits on a pre-tax basis. These plans are sometimes referred to as cafeteria plans. The premium usually is paid by the employee, although the employer may contribute to the premium. Section 125 plans have an annual election period for employees to elect the benefits they want for the coming plan year.

Eligibility for plan enrollment

Section 125 plan enrollment or termination is allowed only:

- When a new hire's eligibility period is satisfied
- During the annual election period
- When a member experiences a life event such as marriage, divorce, death, birth or adoption, termination of employment

Please note, the annual election period is not an open enrollment. Applicable late entrant penalties are based on your policy. The plan year is any 12-month period selected by the employer. Calendar year is the most common.

Family status change

Qualifying life events allow an employee to make mid-plan-year changes outside of the annual election period. Examples include marriage, divorce, birth of a child, death of a spouse or child, and spouse's termination of employment.

Annual election period

If an employee does not elect to participate when initially eligible, the employee may elect to participate at the next annual election period. A member also may elect to cancel coverage or reinstate coverage that was canceled during a previous election period. Applicable late entrant limitations would apply to members or dependents who previously waived or canceled coverage. The election period selected is in your policy under 9070 – Conditions for Insurance.

Late entrant provision

A late entrant is an employee or dependent who does not enroll within 31 days of becoming eligible or who reinstates coverage after canceling. The benefits available would be limited for the amount of time outlined in your policy under 9219 – Limitations. In addition, the premium must be paid during this period and cannot be paid in one lump sum. Check your policy to verify if late entrant limitations apply.

Elect/change/drop members, dependents

With Section 125 plans, employees and their dependents who do not elect coverage within 31 days of becoming eligible cannot enroll until the next annual election period and may be subject to late entrant limitations. Review 9219 – Limitations, and 9060 – Definitions, in your policy to determine if late entrant limitations apply.

Members can elect/change/drop coverage ONLY:

- Within 31 days of the date the employee first becomes eligible, loses eligibility elsewhere, or experiences a qualifying life event
- During the annual election period

If the member drops coverage for reasons other than termination of employment, the change needs to be reported.

Monthly plan payments

Premium payments are due by the first day of the coverage period. If you do not receive your billing statement by the first of the current month, please call 800-659-2223.

To avoid termination of coverage or claims delays, ensure payment is received by the end of the billing cycle. Refer to 9050 – Premiums, and 9323 – Grace Period, in your policy.

Pay by check

Please include the first page of your billing statement along with a check payable to Ameritas Life Insurance Corp. If you made enrollment adjustments, please show how you calculated your payment.

Mail your statement's first page, check and adjustment calculations to:
Ameritas Life Insurance Corp.
P.O. Box 650730
Dallas, TX 75265-0730

Pay by phone

Some groups may qualify to use a pay-by-phone option using a check, debit or credit card. Call 800-659-2223 for more information.

Pay online

If you are signed up for eBill and have completed the Electronic Funds Transfer (EFT) Form online, select the "Pay Bill" function to pay online.

Sign up for EFT

- Access the EFT form through your benefits administrator account.
- Mail both items to: Ameritas Group Administration, P.O. Box 82669, Lincoln, NE 68501-2669

Premium calculation

The amount due appears on the first page of your billing statement and is determined as follows.

+/–	Credit or balance forward
–	Payment received
+	Current month's premium due for active members
+/–	Retroactive credit and/or debit adjustments reflecting enrollment updates
=	Total amount due/check amount

Member termination adjustments

Please note, your premium will not be prorated for members who terminate between premium due dates. However, for retroactive terminations, from the date you notify Ameritas, you may qualify for a refund of unearned premium credit from the most current statement.



Benefits for non-eligible workers

If you have employees who are not eligible to join your group benefits plan, you can offer them Ameritas dental and vision individual plans. The member would pay the premiums and work directly with Ameritas. To see what's available, visit myplan.ameritas.com. Then, contact your Ameritas sales representative or benefits broker to see if there's an individual plan shopping link you can share with workers not eligible for your group benefits plan.

Offer our individual dental and vision benefits to child dependents reaching the dependent age limitation, contracted or seasonal workers, part-time employees, retirees, employees impacted by layoffs, non-covered family members and employees leaving the company.

COBRA continuation of group benefits

This information regarding continuation and COBRA is provided for your information only and is not legal advice. If you have any questions or concerns regarding whether your health plan is subject to COBRA continuation requirements, or any other questions concerning COBRA, seek the advice of legal counsel. In circumstances where a member may elect COBRA, please submit the member's last day worked in the same manner as all other terminations. Once the member has elected COBRA, follow the steps below to reinstate the member retroactive to their termination date.

COBRA enrollment

To enroll a former member or covered dependent for continuation coverage under COBRA, please notify us by filling out an enrollment/change/waiver form and filling in the COBRA box near the top of the form. People choosing COBRA continuation have 60 days to elect the coverage.

When a member elects COBRA continuation of group benefits, you can reinstate that member retroactively to their termination date. Any claims that were denied during the termination period can be reconsidered as long as the provider or member calls us at 800-487-5553 and lets us know which claims require reconsideration.

COBRA coverage will end:

- At the end of 18 months for employee members*
- At the end of 36 months for dependents, unless otherwise noted

Example: A terminated employee is eligible for a maximum of 18 months of COBRA coverage. A dependent spouse who loses coverage due to divorce can elect up to 36 months of coverage.

Notify us if the person:

- Has coverage for 18 months; notify us at the end of 18 months for an employee*
- Has dependents; notify us at the end of 36 months for dependents (except as noted above)
- Does not pay the premium
- Becomes eligible for Medicare benefits
- Remarries and becomes covered under another plan
- Terminates COBRA coverage; submit the termination in writing to discontinue COBRA coverage — please note that people who terminate COBRA coverage may not be reinstated

The Consolidated Omnibus Budget Reconciliation Act, or COBRA, became law on July 1, 1986. In general, the law requires a policyholder who employs 20 or more people to provide continuation of health care benefits to employees who lose their coverage due to a qualifying event. This includes being laid off, terminated, retired or fired for reasons other than gross misconduct. The law also allows continuation of benefits for dependents who lose coverage due to death of the member or divorce. Some states have insurance continuation legislation. These state laws, if applicable, would run concurrently with COBRA.

COBRA members can add/update/drop dependent coverage, but the coverage is limited to the continuation period. COBRA members are responsible for paying their premiums, and it's important to know that we cannot accept personal checks from the member. The amount charged is based on the same rates charged for active/retired employees and their dependents. You may add 2 percent of the premium to the rate charged and retain that 2 percent fee to cover your administrative expenses. You would be responsible for collecting the member's COBRA premium and including it with your regular premium payment.

**An employee who is disabled according to Social Security rules may be eligible for up to an additional 11 months.*



Member account

Members can access benefit information anytime, anywhere through their **member account**. Once signed in, members have access to:

- View plan coverage details
- See a claim status and benefit payment explanation
- View, print or save ID cards to their digital wallet
- Search for network providers
- Nominate a dentist to be part of the network

Members can also download the **Ameritas Benefits app** to access benefit information on their phone.

Claims

Dental claims

When visiting a network provider, there are no claim forms to submit and members to not have to pay upfront. Members can provide authorization for payments to be made directly to out-of-network providers. Members also may ask their dentist's office to submit a pretreatment estimate from Ameritas. The pretreatment estimate is based on their plan benefits. Members will receive a direct response from Ameritas showing exactly how their plan will cover a proposed service so there are no surprises.

Vision claims

Ameritas offers vision plans featuring the VSP or EyeMed network, or a no-network reimbursement plan. VSP or EyeMed network providers typically submit the member's claim. If a member visits an out-of-network provider, they will need to complete an out-of-network vision claim form. With no-network vision plans, members pay their provider, save their itemized receipt, and submit a claim online in their member account for reimbursement up to the plan benefit.

Hearing claims

For hearing claims, the hearing provider or member will need to complete the hearing claim form.
For more information, members can call the dedicated toll-free number for SoundCare at 877-359-8346.

Worldwide support (AXA)

If a member has a dental emergency outside the U.S., AXA Assistance can help. AXA provides credible provider referrals and can even help with making the appointment. Providers referred by AXA are not members of the Ameritas network. Members can call AXA Assistance toll free at 866-662-2731 or collect at 1-312-935-3727.

Contact Us

Administration

Toll free: 800-659-2223
Fax: 402-467-7338
Monday-Thursday: 7 a.m. to 7 p.m. CST
Friday: 7 a.m. to 5:30 p.m. CST

Ameritas Group Administration
P.O. Box 82669
Lincoln, NE 68501-2669

Email: group_assistants@ameritas.com

Billing payments

Ameritas Life Insurance Corp.
P.O. Box 650730
Dallas, TX 75265-0730

Overnight mail or courier
Lockbox 650730
1501 N. Plano Rd., Suite 100
Richardson, TX 75081

Please include the first page of your billing statement with payments by mail. Make check payable to Ameritas Life Insurance Corp.

Or, sign up for EFT payments through your benefits administrator account.
For ACH/wire payments, please contact Ameritas.

Claims and benefits

Toll free: 800-487-5553
Fax new claims: 402-467-7336
Fax additional info: 402-309-2580
Monday-Thursday: 7 a.m. to Midnight CST
Friday: 7 a.m. to 6:30 p.m. CST

Ameritas Group Claims
P.O. Box 82520
Lincoln, NE 68501

Email: group@ameritas.com

Provider networks

Based on your plan, here's how to find dental and/or vision network providers in your area.

Find a dental provider: dentalnetwork.ameritas.com
Or call Ameritas: 800-487-5553

Find a VSP vision network provider: vsp.com
Or call VSP: 800-877-7195

Find an EyeMed vision network provider: eyemed.com
Or call EyeMed: 866-289-0614

For Ameritas vision plans offering the VSP and/or EyeMed provider networks, Ameritas is your contact for plan administration.

Forms

Forms can be accessed at ameritas.com/employee-benefits/forms. Printed forms are also included in this guide for your convenience.

- GLBA Privacy Notice – Post or distribute to plan participants (English, Spanish versions available at ameritas.com/about/privacy under Dental, Vision and Hearing Care)
- Dental and Vision Enrollment/Change Form
- Dental Enrollment/Change Form
- Vision Enrollment/Change Form
- State-specific enrollment/change/waiver forms available at ameritas.com/employee-benefits/forms
- EFT authorization form (available through your benefits administrator account)

If you have questions or need assistance, please call 800-659-2223.



Our Commitment to Your Privacy

We value your trust. That is why we are committed to protecting your personal information. This notice explains the way we use and protect your personal information. You do not need to take any action, but you do have certain rights that are described in this notice.

Important Notice of Privacy of Information Practices

This Privacy Notice is provided on behalf of the group and individual dental, vision, and hearing care businesses of: Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York. In addition to those companies listed above, Ameritas consists of the following affiliated companies, all of which offer their own Notice of Privacy Practices: Ameritas Investment Company, LLC, Ameritas Advisory Services, LLC, Variable Contract Agency, LLC, Ameritas Investment Partners, Inc.

Information we collect

We collect information about you for the purpose of conducting routine business functions, such as paying your dental, vision and hearing care claims. Following are examples of the types of customer information we may collect about you:

Personal identification and contact information, such as your:

- Name and address
- Date of birth
- Social Security number

Group enrollment information (as applicable):

- Employment status
- Date of hire

Health information, such as:

- the claims information you or your dental, vision or hearing care provider submit to us so we can process your claims and assess your benefits

How we gather your personal information

Most of the information we collect about you comes directly from you. You give us personal information when you purchase an individual policy or when you enroll in your employer's dental, vision and/or hearing care plan. We also may receive information from:

- Your dental, vision and/or hearing care provider
- Governmental agencies
- Independent reporting agencies

Information collected by us from insurance support organizations, such as independent reporting agencies, is maintained by that insurance support organization and may be disclosed to other persons.

How we use and share your personal information

We do not sell or share your information with outside marketers. However, we may share your information outside of Ameritas for the following reasons:

Service providers.
We may share information about you with service providers. Service providers are unrelated companies who perform business transactions for us. We require service providers to keep your information confidential. They are contractually bound to use your information only to perform those services. They are required to have safeguards in place to protect it, and are not permitted to sell, use or disclose your information for their own marketing purposes. Disclosures to service providers are part of our business operations. You may not opt out of these disclosures.

Required by law.
Sometimes the law requires us to share customer information, such as in response to a valid summons, court order, search warrant or subpoena. We must comply with the law and therefore you may not opt out of these disclosures.

Agents and brokers.
We may share your information with your agent or broker so he or she may provide you with efficient and superior service. Our agents and brokers understand the importance of your privacy and they are required by law to maintain your privacy and safeguard your information. We require our agents and brokers to follow our policies in order to keep your personal information private and secure. You may not opt out of these disclosures.

Health or medical information

We will not release your medical or health information to anyone unless we are permitted or required by law to do so. When we are not permitted or required by law to disclose your health or medical information, we will not do so without your written authorization.

Examples:

Permitted by law.
The law permits us to exchange information with your health care provider in order to process your claims and facilitate payment.

Required by law.
The law requires us to disclose your information under a valid court order.

Your rights

This notice is also available on our website. You may request an additional copy by writing, e-mailing or calling the Ameritas Privacy Office as indicated at the end of this notice.

You have the right to review the information we have about you. You must make this request in writing and include your full name, address and policy or account number. We may charge you a reasonable fee for the copies you request.

You have the right to request that we make corrections to the information we maintain about you if you believe our records are incorrect. All requests must be in writing.

We safeguard your personal information

We maintain physical and electronic safeguards for the protection of your personal information. We restrict access of your information to our employees and agents who need it to perform their jobs. Our employees and agents understand the importance of these safeguards. We have trained them in the proper handling of your personal information.

Former customers' personal information

The policies and practices described in this notice apply equally to current and former customers. When you are no longer a customer, we will maintain your information for the period of time required by law and then it is destroyed. As a former customer, however, you will not receive our annual Privacy Notice.

Our privacy policies

This Privacy Notice summarizes the Official Privacy Policy of Ameritas identified on the first page of this notice, which became effective on January 1, 2006. This notice complies with all applicable laws and regulations. If your state's privacy law requires more restrictive practices than those described in this notice, we will apply the more restrictive practices to your information. We may make changes to our privacy policies from time to time. However, if we make a change that impacts the accuracy of the sharing practices that are explained in this notice, we will provide you with a revised Privacy Notice within 30 days.

Special note to our group and individual dental, vision and hearing care plan sponsors and participants:
Our group and individual dental, vision and hearing care plans must also comply with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Our Notice of Protected Health Information Practices more specifically describes our privacy policies with regard to your information. You may contact our Privacy Office to request an additional copy.

You may contact us at:

Ameritas Privacy Office
P.O. Box 81889
Lincoln, NE 68501-1889
1-888-284-7844
privacy@ameritas.com

Nevada residents: This notice is being provided pursuant to state law. If you prefer not to receive marketing calls, contact your agent or broker directly. For more information about this law, contact the Office of the Nevada Attorney General, Bureau of Consumer Protection, 100 N. Carson Street, Carson City, NV 89703. Phone number: 702-486-3132; email: www.aginfo@ag.nv.gov.

Nuestro compromiso de privacidad con usted

Valoramos su confianza. Es por eso que nos comprometemos a proteger su información personal. Esta notificación explica cómo utilizamos y protegemos su información personal. No necesita tomar ningún tipo de medida, pero sí le corresponden ciertos derechos que se describen en la presente notificación.

Notificación importante sobre prácticas de privacidad de la información

Esta notificación se proporciona en nombre de las líneas de negocio para la atención dental, oftalmológica y de la audición, tanto grupal como individual, de Ameritas Life Insurance Corp. y Ameritas Life Insurance Corp. of New York. Además de Ameritas Life Insurance Corp. y Ameritas Life Insurance Corp. of New York, Ameritas están formadas por las siguientes compañías afiliadas: Ameritas Investment Company, LLC, Ameritas Advisory Services, LLC, Variable Contract Agency, LLC, Ameritas Investment Partners, Inc.

Qué información recolectamos

Recolectamos información acerca de usted con el fin de llevar a cabo funciones comerciales de rutina, tales como pagar sus reclamos de atención dental, oftalmológica y de la audición. Los siguientes son ejemplos de los tipos de información de clientes que podemos recolectar sobre usted::

Información de identificación personal y de contacto, tal como su:

- Nombre y dirección
- Número de seguro social
- Fecha de nacimiento

Información de inscripción grupal (si así aplica), tal como su:

- Condición laboral
- Fecha de contratación

Información médica como por ejemplo:

- la información de reclamos que usted o su proveedor de atención dental, oftalmológica y de la audición presentan ante nosotros para que podamos procesar dichos reclamos y determinar los beneficios.

Cómo reunimos su información personal

La mayor parte de la información que recolectamos sobre usted proviene directamente de usted mismo. Usted nos provee información personal cuando adquiere una póliza individual o cuando se inscribe en el plan de atención dental, oftalmológica y de la audición de su empleador. También podemos recibir información de:

- Su proveedor de atención dental, oftalmológica y/o de la audición
- Agencias gubernamentales
- Agencias de informes independientesInformation collected by us from insurance support organizations, such as independent reporting agencies, is maintained by that insurance support organization and may be disclosed to other persons.

La información que recolectamos por parte de organizaciones de asistencia para aseguradoras, tales como agencias independientes de datos, es administrada por dichas organizaciones y puede que sea compartida con otras personas.

Cómo utilizamos y compartimos su información personal

No vendemos ni compartimos su información con comerciantes externos. Sin embargo, es posible que compartamos su información fuera de Ameritas por las siguientes razones:

Proveedores de servicios.
Podemos compartir su información con proveedores de servicios. Los proveedores de servicios son compañías no relacionadas que llevan a cabo transacciones comerciales para nosotros. Requerimos que los proveedores de servicios mantengan la confidencialidad de su información. Están contractualmente obligados a utilizar su información únicamente para prestar dichos servicios.

Están obligados a implementar medidas de seguridad para proteger dicha información y no están autorizados a venderla, utilizarla ni divulgarla para sus propios fines de mercadotecnia. Las divulgaciones a los proveedores de servicios son parte de nuestras operaciones comerciales. No puede optar por que no se realicen estas divulgaciones.

Ameritas®

Exigido por ley.
En ocasiones la ley nos exige que compartamos la información de los clientes por ejemplo, en respuesta a una citación, orden judicial, orden de allanamiento u orden de comparecencia válida. Debemos cumplir con la ley y por ende usted no puede optar para que no se realicen dichas divulgaciones.

Agentes e intermediarios.
Podemos compartir la información con su agente o intermediario a fin de que pueda brindarle el mejor y más eficiente servicio. Sus agentes e intermediarios comprenden la importancia de su privacidad y la ley les exige que mantengan y resguarden su información. Nosotros exigimos que nuestros agentes e intermediarios cumplan con nuestras políticas para que su información personal permanezca privada y segura. No puede optar por que no se realicen estas divulgaciones.

Información médica o de salud.

No revelaremos su información médica o de salud a nadie a menos que la ley nos permita o nos exija hacerlo. Cuando la ley no nos permite ni exige que divulguemos su información médica o de salud, no lo haremos sin su autorización por escrito.

Ejemplos:

Permitido por ley.
La ley nos permite intercambiar información con su proveedor de atención médica para procesar sus reclamos y facilitar el pago.

Exigido por ley.
La ley nos exige que divulguemos su información mediante una orden judicial válida.

Sus derechos

Esta notificación también se encuentra disponible en nuestro sitio Web. Puede solicitar una copia adicional por escrito, por correo electrónico o por teléfono a Ameritas según se indica al final de la presente notificación.

Tiene derecho a revisar la información que poseemos sobre usted. Debe realizar esta solicitud por escrito e incluir su nombre completo, dirección y número de póliza o cuenta. Es posible que le cobremos un cargo razonable por las copias que solicite.

Tiene derecho a solicitar que realicemos correcciones a la información que conservamos sobre usted si considera que nuestros registros son incorrectos. Todas las solicitudes deben ser por escrito.

Protegemos su información personal

Poseemos medidas de seguridad electrónicas y físicas para la protección de su información personal. Restringimos el acceso a su información a los empleados y agentes que necesitan de ella para realizar sus trabajos. Nuestros empleados y agentes comprenden la importancia de estas medidas de seguridad. Los hemos capacitado para que manejen su información personal correctamente.

HC 1204-GR-SP Rev. 3-26

Información personal de nuestros ex clientes

Las políticas y prácticas descritas en esta notificación se aplican por igual a clientes actuales y ex-clientes. Cuando usted deje de ser cliente, conservaremos su información por el período de tiempo exigido por ley y luego la destruiremos. Sin embargo, por ser ex cliente, usted no recibirá nuestra notificación de privacidad anual.

Nuestras políticas de privacidad

Esta notificación de privacidad resume la política de privacidad oficial de Ameritas que se identifican en la primera página de la presente, cuya vigencia comenzó el 1 de enero de 2006. Esta notificación cumple con todas las leyes y reglamentaciones vigentes. Si la ley de privacidad de su estado exige prácticas más restrictivas que las descritas en la presente notificación, aplicaremos las prácticas más restrictivas a su información. Podemos realizar cambios a nuestras políticas de privacidad periódicamente. Sin embargo, si realizamos algún cambio que afecte la exactitud de las prácticas para compartir información que se explican en esta notificación, le enviaremos una notificación de privacidad revisada dentro de treinta días.

Notificación especial para los patrocinadores y participantes de nuestro plan dental, oftalmológico y de audición:
Nuestros planes dentales, oftalmológicos y de audición deben cumplir también con los requisitos de privacidad de la Ley de Responsabilidad y Portabilidad del Seguro Médico (HIPAA) y de la Ley de Tecnologías de la Información Médica para una Salud Clínica Rentable (HITECH). Nuestra notificación de prácticas de información médica protegida describe más específicamente nuestras políticas de privacidad con respecto a su información. Puede comunicarse con nuestra oficina de privacidad para solicitar una copia adicional.

Usted puede comunicarse con nosotros:

Ameritas Privacy Office
P.O. Box 81889
Lincoln, NE 68501-1889
1-888-284-7844
privacy@ameritas.com

Residentes de Nevada: Esta notificación se proporciona de conformidad con la legislación estatal. Si prefiere no recibir llamadas de mercadotecnia, comuníquese directamente con su agente de seguros. Para obtener más información acerca de esta legislación, comuníquese con la Oficina del Fiscal General de Nevada, Bureau of Consumer Protection, 100 N. Carson Street, Carson City, NV 89703. Número telefónico: 702-486-3132; correo electrónico: ww.aginfo@ag.nv.gov.

Ameritas

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Ameritas

Policy and Div. # **010-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ Eye Care ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address *(limit of 60 characters)* _____

Are you covered under another **dental** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Are you covered under another **eye care** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental add	Dental drop	Eye Care add	Eye Care drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1 _____	☐	☐	☐	☐					☐
2 _____	☐	☐	☐	☐					☐
3 _____	☐	☐	☐	☐					☐
4 _____	☐	☐	☐	☐					☐
5 _____	☐	☐	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ _____

Employee Signature (do not print) **Date**

X _____ _____

Policyholder Signature (do not print) **Date**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Note for California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For group policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-3797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Note for Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Note for Georgia, Kansas, Nebraska, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Note for Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Maryland Insureds: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does not satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

Note for Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

Note for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note for Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Note for Texas Residents: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Note for Washington, D.C. Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number –** to make sure plan members are added to the correct group.
- **Department/Division Numbers –** so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers –** the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date –** needed so the correct effective date is calculated for new members.
- **Class Number –** needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce…) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

1) submit clear, legible enrollment forms.
2) underline or circle important information.
3) use blue or black ink.

Don't:

1) submit dark copies as they appear black on imaging.
2) highlight, which blackens the area so it cannot be read.
3) write on the top or bottom margins. This information is not always captured on the image system.

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Ameritas

Policy and Div. # **010-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental add	Dental drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐					☐
2	☐	☐					☐
3	☐	☐					☐
4	☐	☐					☐
5	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ **X** _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

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Note for Washington, D.C. Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

tips for filling out this form

To Enroll

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- **Social Security Numbers –** the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date –** needed so the correct effective date is calculated for new members.
- **Class Number –** needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce…) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

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enrollment / change / waiver Group Insurance Form

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Ameritas

Policy and Div. # **010-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Eye Care ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **eye care** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Eye Care add	Eye Care drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐					☐
2	☐	☐					☐
3	☐	☐					☐
4	☐	☐					☐
5	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides eye care benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ **X** _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Note for California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For group policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-3797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Note for Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Note for Georgia, Kansas, Nebraska, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Note for Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Maryland Insureds: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does not satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

Note for Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

Note for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note for Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Note for Texas Residents: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Note for Washington, D.C. Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number –** to make sure plan members are added to the correct group.
- **Department/Division Numbers –** so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers –** the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date –** needed so the correct effective date is calculated for new members.
- **Class Number –** needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce…) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

1) submit clear, legible enrollment forms.
2) underline or circle important information.
3) use blue or black ink.

Don't:

1) submit dark copies as they appear black on imaging.
2) highlight, which blackens the area so it cannot be read.
3) write on the top or bottom margins. This information is not always captured on the image system.

EFT Form

Electronic Funds Transfer Authorization

Ameritas Life Insurance Corp. P.O. Box 82669 / Lincoln, NE 68501 / 800-659-2223 / Fax: 402-467-7332

Request and Authorization for Bank Payment Plan

It's the simplest method of paying your premium. No more checks to write! It's automatic and reliable. We call it electronic funds transfer (EFT for short). It allows for peace of mind however you do business — whether it's online or through the mail.

Online: Groups that receive invoices online, you have the freedom to choose when we debit your account. When you're ready, just visit our website, ameritas.com, sign into your secure account and click PAY BILL. We'll draft your premium payment right away.

Mail: Groups that receive their invoices through the mail, just authorize us to debit your account each month and we'll do the rest. It's the forget-proof method of paying your premium.

Authorized Agreement for Prearranged Payments (Debits)

Group Policy #: **010-**_____ Phone #: _____

Policyholder Name:_____

Policyholder Contact: _____

☐ New Authorization ☐ Change of Account

☐ Checking Account ☐ Savings Account

I hereby authorize Ameritas to initiate debit entries to the account number listed below, and at the bank named below, herein called BANK, to debit the same to such account. The EFT draft will be monthly or quarterly, whichever payment option was selected, on or about the first day of the coverage period.

Bank Account Number: _____ Bank Routing Number *(9 digits)*:_____

Bank Name: _____

Account Name:_____

Address:_____

City: _____ State:_____ ZIP:_____

Phone Number of Financial Institution:_____

To ensure a timely and effective setup, it is preferred that you send a voided check with this request.

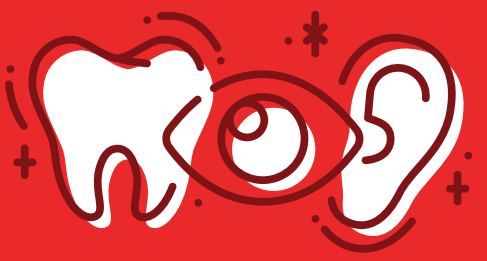
This authorization is to remain in full force and in effect until BANK has received written notification of its termination in such time and such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first. Completion of this request will be 10 or 15 business days after receipt. Please continue to remit payment until you are notified.

Name (print) Title of Authorized Signer

X _____ _____ _____

Signature Date Federal Tax ID#

Please keep a copy of this form for your records.



We help create beautiful smiles, put life into focus and promote good health. We're proud to be part of your benefits program, and we'll make benefits administration easy for you.

Ameritas
fulfilling life.

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