

**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



Policy and Div. # 010- \_\_\_\_\_ **COBRA:** If individual is a continuee: \_\_\_\_\_ Qualifying Event \_\_\_\_\_ Date of Event \_\_\_\_\_  
Cert. # \_\_\_\_\_

Name and Address of Employer (Policyholder) \_\_\_\_\_

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

**Employee Information**

Marital Status  Single  Married  Civil Union (as defined by state law or your Group)  Domestic Partner (as defined by state law or your Group)  
Illinois defines a civil union as a legal relationship between 2 persons, of either the same or opposite sex, established pursuant to Illinois law. This policy provides parties to a civil union and a marriage identical benefits and protections, as required by the Illinois Religious Freedom Protection and Civil Union Act.

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		Eye Care		Relationship	Sex	Date of birth	Social Security no.	College student?
	add	drop	add	drop					
1 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
2 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
3 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
4 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
5 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>

**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** \_\_\_\_\_ **Date** \_\_\_\_\_ **X** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Employee Signature (do not print)** **Policyholder Signature (do not print)**

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
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**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.

## 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.