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-** ____________________

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		Eye Care		Relationship	Sex	Date of birth	*Social Security no.	College student?
	add	drop	add	drop					
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: 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, Oregon, 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 and 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. **Social Security Number is optional.*
- **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.

We provide interpretation services for limited English proficient members.

If you, or someone you're helping, has questions about **your dental pla**n, you have the right to get help and information in your language at no cost. To talk to an interpreter, call **888-845-7444**.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de **su plan dental**, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al **888-845-7444**.

如果您，或是您正在协助的对象，有关于**您的牙医计划**方面的问题，您有权利免费以您的母语得到帮助和信息。洽询一位翻译员，请拨电话 **888-845-7444**。

Nếu bản thân, hay người nào đó mà quý vị giúp đỡ, có thắc mắc về **chương trình nha khoa của quý vị**, quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi số **888-845-7444**.

귀하 또는 귀하께서 돕고 있는 누군가가 **귀하의 치과 플랜**에 대해 궁금한 사항이 있다면, 귀하께서는 별도의 비용 없이 도움과 정보를 귀하의 언어로 받으실 권리가 있습니다. 통역사와 통화하시려면 888-845-7444 번으로 전화해 주십시오.

Kung ikaw, o ang isang taong tinutulungan mo, ay may mga katanungan tungkol sa **iyong plano sa ngipin**, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin, tumawag sa **888-845-7444**.

Если у Вас или у лица, которому Вы помогаете, есть вопросы по поводу **Вашего плана стоматологического обслуживания**, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по телефону **888-845-7444**.

إذا كان لديك أو لدى أي شخص تساعده أي استفسارات بخصوص **برنامج علاج الأسنان الخاص بكم**، فيحق لكم الحصول على المساعدة والمعلومات بلغتكم بدون أي تكلفة. وللتحدث مع مترجم يرجى الاتصال برقم **888-845-7444** .

Si ou menm, oswa yon moun ke w ap ede, gen kesyon sou **plan dantè w**, ou gen dwa pou jwenn èd e enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele **888-845-7444**.

Si vous, ou une personne que vous aidez, avez des questions concernant **votre régime de soins dentaires**, vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour parler à un interprète, appelez le **888-845-7444**.

Jeżeli Pan/i lub ktoś komu pomagacie ma pytania na temat **waszego planu dentystycznego**, można skorzystać z bezpłatnej pomocy i informacji w waszym języku. Aby porozmawiać z tłumaczem należy zadzwonić pod numer **888-845-7444**.

Se você, ou alguém que esteja ajudando, tiver alguma pergunta sobre **o plano odontológico**, você tem o direito de obter ajuda e informações em seu idioma sem nenhum custo. Para falar com um intérprete, ligue para **888-845-7444**.

Se voi, o qualcuno che state aiutando, avete domande circa il **vostro piano odontoiatrico**, avete il diritto di ottenere gratuitamente informazioni nella vostra lingua. Per parlare con un interprete, potete contattare il numero **888-845-7444**.

あなた自身、またはあなたが現在助けている方が**ご自身の歯科保健制度**について質問がある場合、ご希望の言語でサポートおよび情報を無料で受ける権利があります。通訳者が必要な方は、電話番号 888-845-7444 までご連絡ください。

Sie haben das Recht auf kostenlose Hilfe und Information in Ihrer Muttersprache, falls Sie, oder jemand dem Sie helfen, Fragen zu **Ihrer Zahnversicherung** haben. Bitte wählen Sie **888-845-744**4, um einen Dolmetscher zu erreichen.

اگر شما، یا کسی که شما به او کمک میکنید ، در مورد **بیمه دندانپزشکی شما** سوالي داشته باشید ، ابن حق را دارا می باشید که به زبان خود و به طور رایگان کمک و اطلاعات دریافت نمایید. برای صحبت با مترجم با شماره تلفن **888-845-7444** . تماس حاصل نمایید