

# 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. # 030- _____ Cert. # _____	<b>COBRA:</b> If individual is a continuee: _____	Qualifying Event _____	Date of Event _____
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Name and Address of Employer (Policyholder) \_\_\_\_\_

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

<b>Select plan</b>	<input type="checkbox"/> Dental High	<input type="checkbox"/> Eye Care VSP
	<input type="checkbox"/> Dental Low	<input type="checkbox"/> Eye Care EyeMed

## 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.
	add	drop	add	drop				
1 _____	<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"/>				
3 _____	<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"/>				
5 _____	<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.

<b>X</b> _____	<b>Date</b> _____	<b>X</b> _____	<b>Date</b> _____
<b>Employee Signature (do not print)</b>		<b>Policyholder Signature (do not print)</b>	

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 _____	Effective Date	Class	Dep. Code
Dependent late entrant date _____			

## 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, 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 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 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 is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefit plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at [www.bewellnm.com](http://www.bewellnm.com) or call 1-833-862-3935 (TTY: 711).

This plan may contain limitations for replacement of missing teeth. Please see LIMITATIONS for details.

**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.

including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

**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.