Dental and Vision Enrollment Form

Insured by Ameritas Life Insurance Corp.

AMERITAS LIFE INSURANCE CORP.
P.O. Box 81889
Lincoln, NE 68501-1889
800-659-2223 / Fax: 402-467-7338

Administered by HealthPlan Services

Current member of AVMA ☐ Yes ☐ No Current employee of an AVMA member ☐ Yes ☐ No
AVMA membership number _____ (required for all applicants)

Enroll in ☐ **Dental** Select Plan ☐ **High** ☐ **Low** ☐ **Vision** Select Plan ☐ **High** ☐ **Low**

Applicant 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)
Social Security number _____ E-mail address _____
Primary Applicant's last name, first name, MI _____
Date of birth _____ ☐ Male ☐ Female Phone number ( ) _____
Full time date of hire _____ Requested effective date ____/____/____
Occupation _____
Hours worked each week _____ Are your earnings paid: ☐ Hourly or ☐ Salaried
Street address _____ City _____ State _____ ZIP _____
Are you covered under another **dental** insurance plan? . . . . . **Applicant:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No
Are you covered under another **vision** insurance plan? . . . . . **Applicant:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No
Is your employer contributing to your premium? ☐ Yes ☐ No If yes, Employer name _____
Employer street address _____ City _____ State _____ ZIP _____

Dependent Coverage Information

List all eligible dependents to be added. (Applicant must be enrolled to cover dependents)

print full legal name (last, first, MI)	dental add	vision add	relationship	sex	date of birth	social security no.	college student?
1							
2							
3							
4							
5							

Requested Payment Method

☐ Monthly EZ Pay – ONE MONTH PREMIUM REQUIRED (No administration fee) Complete EZ Pay agreement below.
☐ Monthly Direct Billing Option – ONE MONTH PREMIUM REQUIRED ($3 per person, up to $15 maximum administration fee)
☐ Quarterly Direct Billing Option – THREE MONTHS PREMIUM REQUIRED ($8 per quarter administration fee)
☐ Semi-Annual Direct Billing Option – SIX MONTHS PREMIUM REQUIRED ($8 semi-annual administration fee)
Total payment including administration fee with application required. Make checks payable to: **Ameritas Life Insurance Corp.**

If requesting EZ Pay, complete the EZ Pay Agreement. (Only available if employer is NOT contributing premium.)

Payor Name or Depositor if different Relationship to Applicant

Name of Financial Institution _____ Account number _____
Financial Institution Address _____ City _____ State _____ ZIP _____
Specify Type of Account ☐ Checking ☐ Savings
ABA 9 Digit Routing Number (See below or please call your financial institution for assistance) _____

Ameritas and/or HealthPlan Services, acting as Plan Administrator on behalf of Ameritas, is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month, until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Certificate is not issued. ■ I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by HealthPlan Services, and I agree that the bank named shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Ameritas and/or HealthPlan Services in writing.

X _____
Primary Payor Signature **Date**

Joe Smith
123 Main Street
Anytown, IL 12345

ATTACH YOUR INITIAL CHECK OR MONEY ORDER FOR PREMIUM PAYMENT

Date _____
Pay to the order of **AMERITAS LIFE INSURANCE CORP.** $ _____
Dollars
For _____
(123456789) ROUTING NUMBER 1234567891011 1117

EZ PAY PLAN APPLICANTS ONLY

VOIDED CHECK

DEPOSIT SLIPS ARE NOT ACCEPTABLE

please sign (applicant) **The certificate provides dental and vision benefits only. Review your certificate carefully.**
As a member/employee, I hereby apply for 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 _____
Applicant's 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 below.)

Soliciting producer name Bert H. Jacobs, Agent #638

X Bert H Jacobs
Soliciting Producer's Signature **Date**

Once completed, signed and dated, mail this form along with your premium payment to:
AVMA GHLIT C/O HealthPlan Services, P.O. Box 30475, Tampa, FL 33630-3475, Phone: 800-621-6360

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 877-233-2797. 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 Maryland and Washington, D.C. Residents: 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 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 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 Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.