our administration guide

Ameritas
fulfilling life

GR 6012 HPS Rev. 11-13

welcome

At Ameritas Group, a division of Ameritas Life Insurance Corp. (Ameritas Life), we do more than provide coverage. We help create beautiful smiles. We put life into focus. We promote good health.

Thank you for selecting us as the insurance carrier for your group. We're proud to be part of your benefits program and want to do everything we can do to make administration simple.

Keep this administration guide as a reference; however, please note that some information in this guide may not apply to your specific policy.

Contact us anytime with questions:

Administrative inquiries

Ameritas Life Insurance Corp.
Healthplan Customer Service
P.O. Box 30284
Tampa, FL 33630-3284
Toll Free Phone: 877-803-5357
Fax: 877-457-2201
Monday - Thursday: 8 a.m. - 8 p.m. (ET)
Friday: 8 a.m. - 6:30 p.m. (ET)

Premium payment inquiries

Ameritas Life Insurance Corp.
Healthplan Customer Service
P.O. Box 864793
Orlando, FL 32886-4793
Toll Free Phone: 877-803-5357
Monday - Thursday: 8 a.m. - 8 p.m. (ET)
Friday: 8 a.m. - 6:30 p.m. (ET)

table of contents

privacy notice 5

enrollment 7
adding member coverage
for section 125 plans

effective dates for members 8
exception to member effective date
reinstatement or rehires

effective dates for dependents 8

conditions for eligibility 9
members
dependents

section 125 eligiblity requirements 9
general information
family status change
annual election period
late entrant provision

change dependent coverage 10

special circumstances 10
same employer spouse provision
total disability
exception to dependent definitions
note for Section 125 Plans

update member information 10
correcting member information

change policy provisions and/or addition of benefits 11

terminate member coverage 11
member termination notification
note for Section 125 Plans

premium payment 12
due dates
payment by check
eBill
payment through electronic funds transfer (EFT)

premium accounting 12

sample billing statement 13

COBRA enrollment and termination 16

continuation of coverage – COBRA 16

eServices overview 17
eEnroll
eBill and electronic funds transfer (EFT)
eView
eCert

request eServices 17

enrollment/change/waiver form information 18
enrollment/change/waiver form
enrollment/change/waiver form - dental only
enrollment/change/waiver form - eye care only
request for group forms

Forms

The following forms are included in this administration guide and may be duplicated as needed. These documents and Spanish versions may be found on our website, ameritasgroup.com, under the “Forms” section.

- Dental and Eye Care Enrollment/Change/Waiver Form
- Dental Enrollment/Change/Waiver Form
- Eye Care Enrollment/Change/Waiver Form
- Electronic Funds Transfer (EFT) Forms
- Request for Forms

ATTN. PLAN SPONSORS: Please post or distribute to plan participants

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.

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.

Ameritas

In addition to Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York, Ameritas consists of the following affiliated companies, all of which offer their own Notice of Privacy Practices:

- Acacia Life Insurance Company
- The Union Central Life Insurance Company
- Ameritas Investment Corp.
- Calvert Investments, Inc.
- 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 and vision 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,
  - Social Security number and
  - Date of birth.
- **Enrollment information,** such as your:
  - Employment status and
  - Date of hire.
- **Health information,** such as the claims information you or your dental or vision 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 enroll in your employer's dental and/or vision plan. We also may receive information from:

- Your dental or vision provider,
- Governmental agencies and
- Independent reporting agencies.

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. We prohibit them from using your information for their own purposes or re-disclosing it to anyone. 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.

Ameritas®
fulfilling life®

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

You have the right to receive a copy of this notice at least once each year while you are our customer. This notice is also available on our website. You may request an additional copy by writing, e-mailing or calling the 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.

0ur 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. We are required by law to send you our Privacy Notice at least once each year. 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). 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

Ameritas® is a marketing name for the subsidiaries of Ameritas Mutual Holding Company, including, but not limited to, Ameritas Life Insurance Corp., Ameritas Life Insurance Corp. of New York and Ameritas Investment Corp., member FINRA/SIPC. Ameritas Life Insurance Corp. is not licensed in New York.

Ameritas® and the bison design are registered service marks of Ameritas Life Insurance Corp.
© 2014 Ameritas Mutual Holding Company

enrollment

Adding member coverage

If you participate in eServices, you can go to our website, ameritasgroup.healthplan.com, “Employers” section to add member coverage.

If you do not participate in eServices, you should complete the enrollment/change or waiver form, “Enrollment” section and mail or fax it to:

Ameritas Life Insurance Corp.
Healthplan Customer Service
P.O. Box 30284
Tampa, FL 33630-3284
Fax: 877-457-2201

The completed form must contain the following required information:

1. Name
2. Gender
3. Date of birth
4. Full time date of hire
5. Accurate name of the policyholder and the policy number
6. Election of coverage for dependents
7. Signature of member

Incomplete sections or missing signatures may delay member enrollment.

The employee needs to elect coverage within 31 days of becoming eligible.

The enrollment form is included in this administration guide and may be duplicated as needed. A copy of the form may be obtained from our website, ameritasgroup.com, under the “Forms” section.

Note for Section 125 Plans

Employees who do not elect coverage within 31 days of becoming eligible cannot enroll until the next annual election period and may be subject to limited benefits outlined in the “9219 - Limitations” section of the policy. Please review “9060-Definitions” section of the policy to determine if the late entrant provision applies to your policy. Employees may only enroll 31 days after becoming eligible if there is a change in family status.

We will send you the member’s ID card and/or certificate of coverage after the member is enrolled; we won’t return the original enrollment form. If you need the enrollment form for your records, please make a copy before submitting it.

effective dates for members

Members

Each employee has the option of being insured and insuring his or her dependents. To elect coverage, the employee will agree in writing to contribute to the payment of insurance premiums. The effective date for each member and his or her dependents is:

1. The date on which the member qualifies for insurance, if the member agrees to contribute on or before that date
2. The date on which the member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance
3. The date we accept the member and/or dependent for insurance when the member and/or dependent is a late entrant. The member and/or dependent will be subject to any limitation concerning late entrants.

Note: Some policies do not allow employees to waive coverage for themselves or their dependents. If dependent waivers are allowed, the employee must agree in writing to contribute to the payment of the insurance premiums.

Examples:

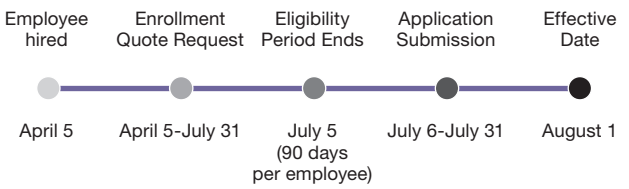
Date Enrollment Form Signed

1. On or before eligibility period is satisfied
2. Within 31 days after eligibility period is satisfied
3. Over 31 days after eligibility period is satisfied

Effective Date*

1. On date eligibility period is satisfied
2. On date enrollment form is signed
3. On date enrollment form is signed with late entrant limitations.**

Although eligibility periods vary based on the policy, here is an example of a 90 day eligibility period:



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

** Late entrant limitations apply to dental and may apply to eye care coverage.

Exception to member effective date

If employment is the basis for membership, an employee needs to be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day the employee returns to active service.

Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with the employer on a full time basis at one of the employer's business establishments or at some location to which the business requires travel.

Reinstatement or rehires

If employment is the basis for membership in the eligible class for members, an insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

effective dates for dependents

Each employee has the option of being insured and insuring his or her dependents.

To elect coverage, the employee agrees in writing to contribute to the payment of the insurance premiums. The effective date for each member, and his or her dependents, will be the first of the month falling on or first following:

1. The date on which the member qualifies for insurance, if the member agrees to contribute on or before that date
2. The date on which the member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance
3. The date we accept the member and/or dependent for insurance when the member and/or dependent is a late entrant. The member and/or dependent will be subject to any limitation concerning late entrants.

conditions for eligibility

Members

Requirements for eligibility are defined in the "9070 - Conditions for Insurance Coverage" section of the policy. An example of a requirement may be: "If employment is the basis for membership, a member of the eligible class for insurance is any employee working at least 30 hours per week. If membership is by reason other than employment, then a member of the eligible class for insurance is defined by the policyholder." The eligibility period begins when the member meets the policy's eligibility requirements.

The eligibility period is the length of time that must pass after the member becomes eligible until coverage may become effective.

Dependents

The following are eligible dependents of an insured member:

1. The member's spouse (or domestic partner if this coverage is elected.)
2. Each unmarried child less than the age as defined in the "9060 - Definitions" section of the policy, for whom the insured or the insured's spouse is legally responsible, including:
    A. Natural born children
    B. Adopted children, eligible from the date of placement for adoption
    C. Children covered under a Qualified Medical Child Support Order as defined by applicable federal and state laws
3. Each unmarried child as defined in the "9060 - Definitions" section of the policy who is:
    A. A full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and
    B. Primarily dependent on the insured, the insured's spouse for support and maintenance.

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

Review the group policy to identify the specific eligibility requirements for your plan. For clarification you can call our customer service department toll free at 877-803-5357.

Additional information

For other conditions or exceptions of eligibility, refer to page 12. For continuation of coverage - COBRA, refer to page 21.

section 125 eligiblity requirements

General information

DETAILS ABOUT THE SECTION 125 REQUIREMENTS ARE FOUND AT 26 U.S.C. 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 with pre-tax earnings. These plans are sometimes referred to as "cafeteria plans." The premium is usually paid by the employee although the employer may contribute to the premium. Section 125 plans have an "Annual Election Period" each year for employees to "elect" the benefits they want for the coming plan year. Enrollment or termination is allowed only at:

- New hire satisfaction of the eligibility period
- Election period
- Life event such as:
    - marriage
    - divorce
    - death
    - birth or adoption
    - termination of employment

The annual election period is not an open enrollment. Late entrant penalties will apply specific to policy provisions. The plan year is any 12 month period for the Ameritas plan offerings selected by the employer (most common is a calendar year).

Family status change

Family status changes allow an employee to make mid-plan year changes in Section 125 plans. Examples include marriage, divorce, birth of a child, death of a spouse or child, and spouse's termination of employment. Refer to Section 125 of the Tax Code and Applicable Treasury Regulations or legal advisor for information regarding family status changes.

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 may also elect to cancel coverage or reinstate coverage canceled at a previous election period. The election period selected by the Employer, is referenced in the "9070 - Conditions for Insurance" section of the policy. Late entrant limitations will apply to any member or dependent who previously waived or canceled coverage.

Late entrant provision

A late entrant is a member or dependent who does not enroll within 31 days of becoming eligible or who reinstates coverage after canceling. The benefits available to the late entrant will be limited for the amount of time outlined in the "9219 - Limitations" section of the policy. The premium must be paid continuously during this period and cannot be paid in one lump sum.

** Late entrant limitations apply to dental and may apply to eye care coverage.

change dependent coverage

Adding and removing dependent coverage

If you participate in eServices, you can go to our website, ameritasgroup.healthplan.com, “Employers” section to add or remove dependent coverage.

If you do not participate in eServices, you should complete the enrollment/change or waiver form, “Change” section and mail or fax it to:

Ameritas Life Insurance Corp.
Healthplan Customer Service
P.O. Box 30284
Tampa, FL 33630-3284
Fax: 877-457-2201

The completed form needs to contain the following required information:

1. Reason for change (e.g. marriage, divorce, loss of spousal coverage, child reaching the dependent coverage age limitation)
2. The date the dependents qualified for coverage, and/or
3. The date for which the dependent coverage should terminate

Note for Section 125 Plans

As with employees, late enrollments of dependents at the annual election period may result in limited benefits for the time specified in the “9219 - Limitations” section of the policy if the addition is not due to a family status change.

Please review “9060-Definitions” section of the policy to determine if the late entrant provision applies to your policy.

The enrollment form is included in this administration guide and may be duplicated as needed. A copy of the form may be obtained from our website, ameritasgroup.healthplan.com, under “Employers” then “resource center” section.

special circumstances

Same employer spouse provision

The Same Employer Spouse Provision applies to a husband and wife who are both employees of the policyholder and have eligible dependent children. Refer to the group policy, “9070 - Conditions for Insurance Coverage” section, to determine if this provision is included in your plan.

This provision allows for one spouse to elect to carry the employee coverage and the other spouse to be covered as a dependent of that employee along with the children. The spouse is covered as a dependent and is not covered as an employee.

Total disability

Total disability describes the member’s dependent as continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and chiefly dependent upon the insured for support and maintenance.

Exception to dependent definitions

We may make exceptions to dependent coverage for dependents that are not natural born, adopted, or stepchildren of the member, but meet the age limitation requirements found in the “9060 - Definitions” section of the policy under the following circumstances:

1. The member has legal guardianship of the dependent(s)
2. The dependent is covered by the member’s medical carrier
3. The member legally claims the dependent for tax reporting purposes

update member information

We understand that changes to member’s personal record information is occasionally necessary.

Examples include:

1. Change or correction to the spelling of a member’s name
2. Correction of a date of birth
3. Change of address
4. Correction of a Social Security number or member identification number

Correcting member information

1. If you participate in eServices, you can go to our website, ameritasgroup.healthplan.com, “Employers” section to update member information.
2. If you do not participate in eServices, you can complete the enrollment/change or waiver form, “Change” section and mail or fax it to:

   Ameritas Life Insurance Corp.
   Healthplan Customer Service
   P.O. Box 30284
   Tampa, FL 33630-3284
   Fax: 877-457-2201

3. You may also call our customer service department toll free at 807-803-5357.

change policy provisions and/or addition of benefits

Policy provisions may need to change from time to time.

Examples include:

1. Change of company name
2. Change of eligibility period
3. Change in the number of hours worked to qualify for group coverage
4. Addition of other product benefits such as dental, eye care or LASIK coverage changing policy provisions

You should contact your Ameritas Group representative or producer regarding the policy changes you wish to make. Some changes may require additional underwriting and may affect your current premium rates.

You will need to describe the desired change including your requested effective date on your letterhead and have it signed by a person authorized to represent the company and then mail or fax it to:

Ameritas Life Insurance Corp.
Healthplan Customer Service
P.O. Box 30284
Tampa, FL 33630-3284
Fax: 877-457-2201

terminate member coverage

Member termination notification

If you participate in eServices, you can go to our website, ameritasgroup.healthplan.com, “Employers” section to terminate member coverage.

If you do not participate in eServices, you may complete any of the following:

1. List terminated members on page (1) of the premium statement and note the last day worked
2. Draw a line under the member’s name on the itemized listing and note the last day worked
3. Call our administration and billing department toll free at 877-803-5357
4. Complete the enrollment/change or waiver form, “Change” section and note the last day worked and mail or fax it to:

Ameritas Life Insurance Corp.
Healthplan Customer Service
P.O. Box 30284
Tampa, FL 33630-3284
Fax: 877-457-2201

Note for Section 125 Plans

Employees and/or their dependents, may only terminate coverage at the annual enrollment period unless there is a family status change. If the member drops coverage for a reason other than termination of employment the status change must be reported.

It is in the policyholder’s best interest to report terminations promptly. Without current member eligibility information, Ameritas may receive and inadvertantly pay a claim for expenses incurred after the termination date. In such cases, we may hold the policyholder liable for additional premium.

Please note that coverage ends as of the date the member ceases to be an eligible member, unless your group policy contains an end of month provision. The termination date excludes accrued vacation time or other benefits. No refund is made when termination occurs in the middle of a policy month. Premium should be paid for the full month.

Some members may be eligible for a continuation of coverage; please refer to page 16 for more information.

premium payment

Due dates

Premium payments are due by the first day of the coverage period.

Payment by check

You should attach a copy of the billing statement with a check payable to Healthplan Services and any detail on how you arrived at your payment if manual adjustments were made and mail to:

Ameritas Life Insurance Corp
Healthplan Customer Service
P.O. Box 864793
Orlando, FL 32886-4793

Please call our customer service department toll free at 877-803-5357 if you have not received your statement by the first of the current month. Payments not received by the last day of the billing cycle will be subject to termination of coverage.

eBill

You can perform many of your billing and payment functions online; please see the eBill portion of the eServices overview on page 17.

Payment through electronic funds transfer (EFT)

You may utilize electronic funds transfer (EFT), even if you do not participate in eServices. By utilizing EFT you no longer need to write a check for the premium, and don't have to worry about mailing delays.

The EFT will automatically draft the correct amount of premium from your account at the same time each month.

To make payments through EFT, complete the EFT information on the website and we'll draft your premium amount using EFT.

premium accounting

The total amount due on the front page of the billing statement will reflect any credit balance or balance forward.

The total amount due is determined as follows:

+/–	Any credit or balance forward
–	Payment received
+	Current month's premium due for active members
+/–	Retro credit and/or debit adjustments
=	Total amount due/check amount

The "9050 - Simplified Accounting" section of the policy states that premium will be due as of the first premium due date falling on or after the date the employee's coverage is effective.

Example:

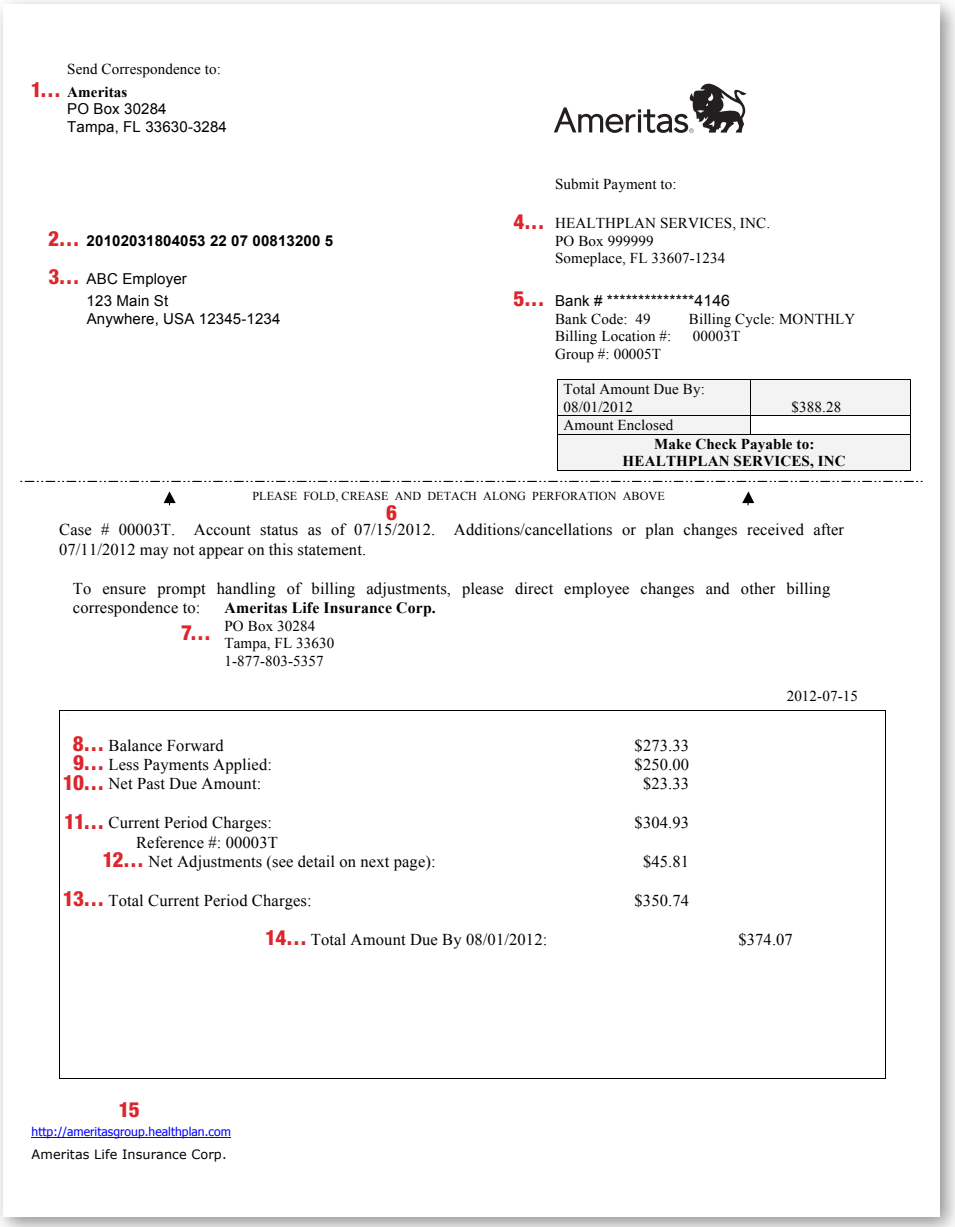
If a member's coverage is effective on January 15 and the premium due date is the first of the month; the first premium due for that member is February 1 (which is the first of the month following the effective date).

Premium will not be prorated for a partial month for members terminated between premium due dates.

From the time you notify us of a retroactive termination, up to three (3) months of unearned premium credit from the most current statement billed may be refunded to you.

It is important to report terminations timely as the policyholder is liable for any benefits released in the period following the termination until we receive the termination information.

sample billing statement



Send Correspondence to:

1... **Ameritas**
PO Box 30284
Tampa, FL 33630-3284

Ameritas

Submit Payment to:

2... **20102031804053 22 07 00813200 5**

4... HEALTHPLAN SERVICES, INC.
PO Box 999999
Someplace, FL 33607-1234

3... ABC Employer
123 Main St
Anywhere, USA 12345-1234

5... Bank # **********4146
Bank Code: 49 Billing Cycle: MONTHLY
Billing Location #: 00003T
Group #: 00005T

Total Amount Due By: 08/01/2012	$388.28
Amount Enclosed	
Make Check Payable to: HEALTHPLAN SERVICES, INC	

PLEASE FOLD, CREASE AND DETACH ALONG PERFORATION ABOVE

6

Case # 00003T. Account status as of 07/15/2012. Additions/cancellations or plan changes received after 07/11/2012 may not appear on this statement.

To ensure prompt handling of billing adjustments, please direct employee changes and other billing correspondence to:

7... **Ameritas Life Insurance Corp.**
PO Box 30284
Tampa, FL 33630
1-877-803-5357

2012-07-15

8... Balance Forward	$273.33
9... Less Payments Applied:	$250.00
10... Net Past Due Amount:	$23.33
11... Current Period Charges:	$304.93
Reference #: 00003T	
12... Net Adjustments (see detail on next page):	$45.81
13... Total Current Period Charges:	$350.74
14... Total Amount Due By 08/01/2012:	$374.07

15

http://ameritasgroup.healthplan.com

Ameritas Life Insurance Corp.

Cover page of billing statement

1. Correspondence address
2. Number bank uses to identify policy
3. Policy billing address
4. Premium payment remittance address
5. Bank account# to identify carrier to bank
6. Date statement was printed. Payments and changes applied on or after this date are not on this statement
7. Address to send employee and other billing correspondence to
8. Balance forward from prior month
9. Payment(s) applied for current billing month
10. Past due amount, balance forward plus any money that has been applied
11. Premium charges for current billing period
12. Any adjustment for current billing period
13. Total amount due for the current billing period
14. Total amount due for this billing statement. PAY THIS AMOUNT
15. Website address

Ameritas
PO Box 30235
Tampa, FL 33630-3235

Ameritas

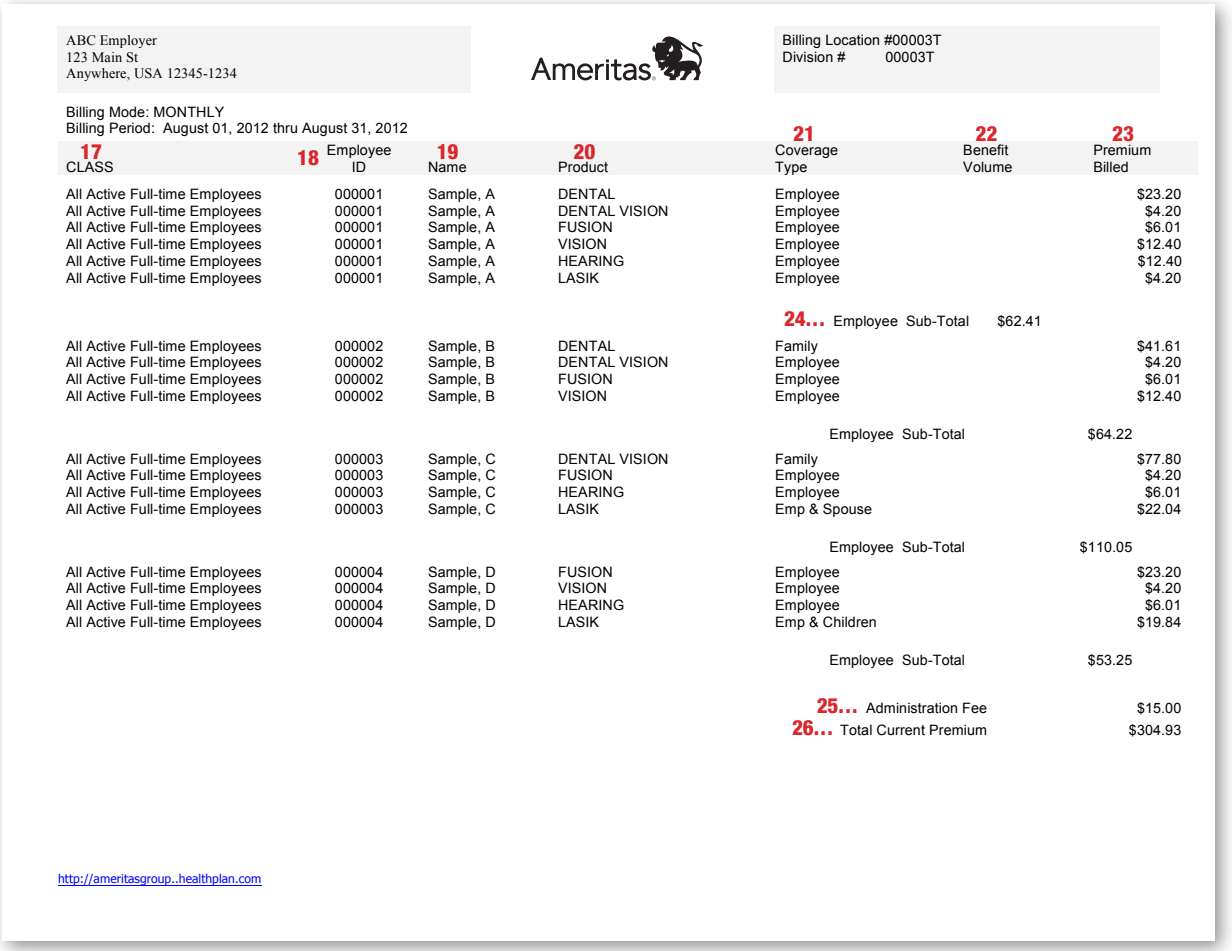
Case # 00003T - ABC Employer
Reference 00005T ABCD Location Adjustments

Employee ID	Name	Description	Adjustment
000001	Sample, A	FIRST BILL, COVERAGE BEGAN 07/01/2012	$12.40
16 000001	Sample, A	FIRST BILL, COVERAGE BEGAN 07/01/2012	$23.20
000001	Sample, A	FIRST BILL, COVERAGE BEGAN 07/01/2012	$4.20
000001	Sample, A	FIRST BILL, COVERAGE BEGAN 07/01/2012	$6.01
		Total Premium Adjustments:	$45.81

http://Ameritas.healthplan.com Underwritten by: Ameritas Life Insurance Corp.

Billing statement – continued

16. Adjustments for previous months premium, such as back premiums for employee enrolled late.



ABC Employer
123 Main St
Anywhere, USA 12345-1234

Ameritas

Billing Location #00003T
Division # 00003T

Billing Mode: MONTHLY
Billing Period: August 01, 2012 thru August 31, 2012

17 CLASS	18 Employee ID	19 Name	20 Product	21 Coverage Type	22 Benefit Volume	23 Premium Billed
All Active Full-time Employees	000001	Sample, A	DENTAL	Employee		$23.20
All Active Full-time Employees	000001	Sample, A	DENTAL VISION	Employee		$4.20
All Active Full-time Employees	000001	Sample, A	FUSION	Employee		$6.01
All Active Full-time Employees	000001	Sample, A	VISION	Employee		$12.40
All Active Full-time Employees	000001	Sample, A	HEARING	Employee		$12.40
All Active Full-time Employees	000001	Sample, A	LASIK	Employee		$4.20
				24... Employee Sub-Total	$62.41	
All Active Full-time Employees	000002	Sample, B	DENTAL	Family		$41.61
All Active Full-time Employees	000002	Sample, B	DENTAL VISION	Employee		$4.20
All Active Full-time Employees	000002	Sample, B	FUSION	Employee		$6.01
All Active Full-time Employees	000002	Sample, B	VISION	Employee		$12.40
				Employee Sub-Total		$64.22
All Active Full-time Employees	000003	Sample, C	DENTAL VISION	Family		$77.80
All Active Full-time Employees	000003	Sample, C	FUSION	Employee		$4.20
All Active Full-time Employees	000003	Sample, C	HEARING	Employee		$6.01
All Active Full-time Employees	000003	Sample, C	LASIK	Emp & Spouse		$22.04
				Employee Sub-Total		$110.05
All Active Full-time Employees	000004	Sample, D	FUSION	Employee		$23.20
All Active Full-time Employees	000004	Sample, D	VISION	Employee		$4.20
All Active Full-time Employees	000004	Sample, D	HEARING	Employee		$6.01
All Active Full-time Employees	000004	Sample, D	LASIK	Emp & Children		$19.84
				Employee Sub-Total		$53.25
				25... Administration Fee		$15.00
				26... Total Current Premium		$304.93

http://ameritasgroup..healthplan.com

Billing statement – continued

17. Class name
18. Unique employee ID in HealthPlan Service system
19. Employee being billed for current month's premium
20. Product employee is being billed for current month's premium
21. Coverage type employee is being billed
22. Does not apply to Dental or Vision coverage
23. Premium being billed per product per employee
24. Subtotal per employee
25. Administration fee, if applicable
26. Current months premium minus adjustments

COBRA enrollment and termination

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, YOU SHOULD 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. Any claims that were denied during the time period of the termination can be reconsidered provided notification by the provider or member that a claim was denied due to termination of coverage. The provider or member may call our customer service department at 800-487-5553 to notify our representatives that a submitted claim needs reconsideration.

Cobra enrollment

To enroll a former member or covered dependent for continuation coverage under COBRA, notify us by filling out the COBRA box at the top of the enrollment/change/waiver form.

Cobra termination

COBRA coverage will cease on the earliest of the following dates:

You must notify us of the occurance of the following events.

1. At the end of 18 months for an employee*
2. At the end of 36 months for dependents (except as noted above)
3. The person's failure to pay the premium for coverage
4. The person's becoming entitled to Medicare
5. With respect to a spouse, upon remarrying and becoming insured under another plan

If an insured elects to terminate COBRA coverage, we require that you submit a written notice. Once you have notified us to discontinue COBRA coverage for an employee, the employee may not be reinstated.

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

continuation of coverage – COBRA

At Ameritas we do not offer a conversion of group coverage to individual coverage. Federal legislation has provided for a continuation of group dental and eye care insurance in the event that coverage terminates under certain qualifying events.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) became law on July 1, 1986. Generally speaking, 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. Qualifying events include events that cause an employee to lose coverage, such as being laid-off, terminated, retired, fired for reasons other than gross misconduct, etc. The law also allows continuation of benefits to dependents who lose coverage due to death of employee, dependents divorce from employee etc.

The maximum length of continuation coverage available under COBRA for a non-disabled employee is 18 months. The same maximum of 18 months of coverage is available to dependents if the qualifying event is a termination or a reduction in hours. Employees who are disabled according to Social Security rules as of their qualifying date may continue coverage for an additional 11 months after the completion of the 18 months if they continue to be disabled. Up to 36 months of continuation is available to dependents for any other qualifying event. For example, an employee who terminates is eligible for a maximum of 18 months coverage continuation, while a spouse who loses coverage due to a divorce can elect up to 36 months.

Some states have insurance continuation legislation. These state laws, if applicable, would run concurrently with COBRA.

Persons choosing COBRA continuation have 60 days from the date notified of their continuation rights to elect the coverage.

A person under COBRA can add or delete dependent coverage as any other covered employee, but coverage is limited to the extent of the continuation period.

The employee or qualified dependent is responsible for paying for the coverage. The amount charged is based on the same rates charged for an active/retired employees and their dependents. The policyholder may add 2 percent of the premium to the rate charged and retain the 2 percent fee for their own administrative expenses. It is the responsibility of the policyholder to collect this premium and remit it to us with the regular premium payment.

Please note that COBRA premiums collected must be included in the payment of premiums for active employees. We do not accept personal checks from the COBRA insureds themselves.

eServices overview

We're here to provide you with quick, accurate solutions. That's why we've expanded our website to include free online services that will make administering your employee benefit plan fast and easy. It's our way of helping make the complicated world of benefits uncomplicated.

eEnroll

- Save time by using our website to enroll, change or terminate member coverage in real-time
- View member coverage status including effective dates, dependent coverage levels, and more
- Sign up for eEnroll, and you're eligible for eBill

eBill and electronic funds transfer (EFT)

- Simply order your bill online and pay online
- Update member information before paying
- View online, or print a list billing that shows your detailed adjustments
- Access a year of premium information and billing history online

eView

- You can always view member effective dates, dependent coverage levels, and more through our website
- View your policy and certificates

eCert

- Allows you to access important plan documents online
- View your policy and certificates
- Distribute certificates electronically by downloading PDF files to attach to an email, or post on your organization's website
- You may print certificates for member reference
- Members may view and print a copy of the certificate, giving them direct access to benefit information
- See the most current documents for your plan, including updates

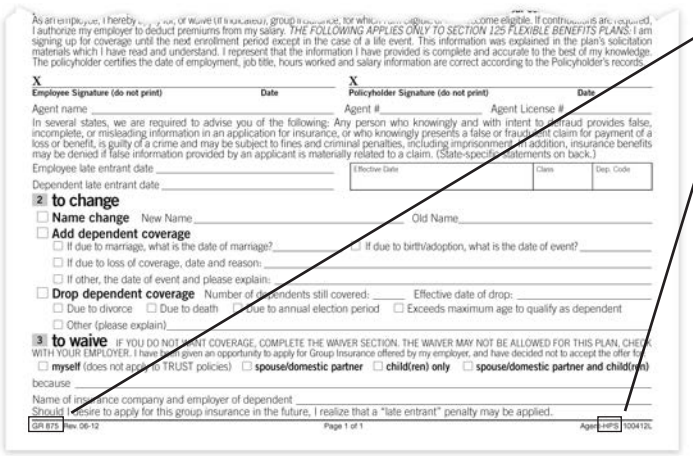
request eServices

To sign-up for eServices:

1. Visit our website at ameritasgroup.healthplan.com
2. On the home page select "Employers"
3. You will be taken to the "Employers Home Page"
4. Select "Employer registration"
5. Complete Account Details by filling in the below information:
    A. Ameritas or HPS policy #
    B. Company name
    C. ZIP code

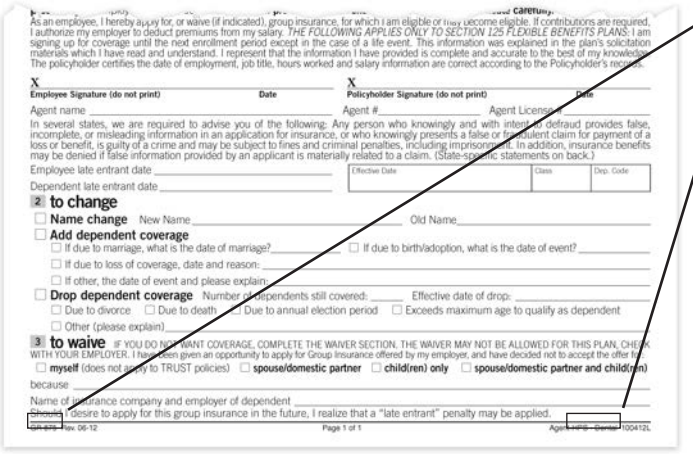
If you need additional assistance, call our customer service department toll free at 877-803-5357.

enrollment/change/waiver form information



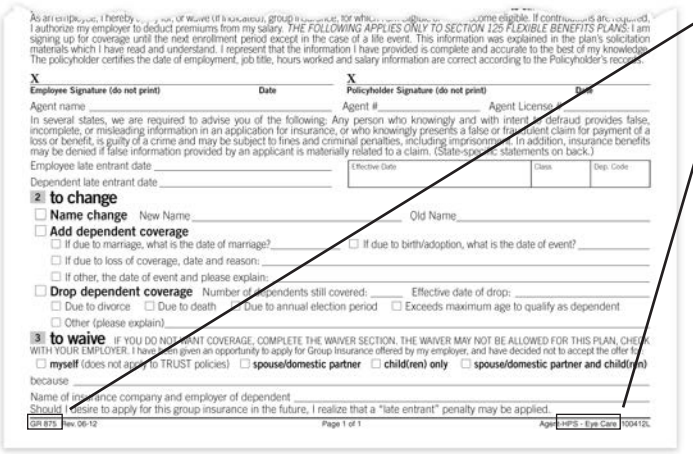
Dental and eye care coverage

If you have dental and eye care coverage with Ameritas, use form “GR875 HPS”.



Dental only coverage

If you have dental coverage with Ameritas, use form “GR875 HPS - Dental”.



Eye care only coverage

If you have eye care coverage with Ameritas, use form “GR875 HPS - Eye Care”.

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 30284 / Tampa, FL 33630-3284 / 877-803-5357 / Fax: 877-457-2201

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 _____ 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: 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 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.
- **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 30284 / Tampa, FL 33630-3284 / 877-803-5357 / Fax: 877-457-2201

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 _____ **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 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.
- **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 30284 / Tampa, FL 33630-3284 / 877-803-5357 / Fax: 877-457-2201

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: 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 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.
- **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.

Request for Group Forms

Ameritas Life Insurance Corp.

FAST, EASY FORMS: For your convenience, various forms are available online at **ameritasgroup.healthplan.com.** Click the "resource center" button on the website(s) for a list of claim, enrollment and producer form PDFs. Simply open the PDF, save it to your computer, then print!

Policyholder/Employer Name: _____

Address: _____

City: _____ State: _____ ZIP: _____ Is this a new address? ☐ Yes ☐ No

Requested By (Your Name): _____ Today's Date: _____

Group Policy/Division Number: 010- _____ - _____ Number of Insured Employees: _____

Quantity	Form No.	Form Description
	GR 875	Group Enrollment/Change or Waiver Form
	GC 140	Dental Claim Form
	2276	Claim Pre-Addressed Envelope *(P.O. Box 82520)*
	GR 5524	Request for Group Forms
	GC 314	Eye Care Claim Form *(for Vision Perfect plans, Dental plans with LASIK and Dental plans with Exam Only benefit)*
	47360	VSP Eye Care Coverage Brochure
	Other	Please attach copy of form

When available, please attach a copy of requested form(s). ***Thank you for your order.***

Mail to: Request for Group Forms
Ameritas Life Insurance Corp.
P.O. Box 30284
Tampa, FL 33630-3284

Order Processed By: _____

Date: _____

notes

Ameritas Life Insurance Corp.

This information is provided by Ameritas Life Insurance Corp. [Ameritas Life]. Group dental, vision and hearing care products [9000 Rev. 03-08, dates may vary by state] and individual dental and vision products [Indiv. 9000 Ed. 11-09] are issued by Ameritas Life. Some plan designs are not available in all areas. In Texas, our PPO network and plans are referred to as the Ameritas Dental Network. Some states require that producers be appointed with Ameritas Life before soliciting its products. To become appointed with Ameritas Life, please call 800-659-2223. Most plans for groups with 26 or more enrolled lives are administered by Ameritas Life. Billing and eligibility for most plans with 25 or fewer enrolled lives are provided by HealthPlan Services, Inc.

Ameritas, the bison design, “fulfilling life” and product names designated with SM or ® are service marks or registered service marks of Ameritas Life or its affiliate Ameritas Holding Company. All other brands are property of their respective owners. © 2013 Ameritas Mutual Holding Company.

800-776-9446 | ameritasgroup.com

GR 6012 HPS Rev. 11-13