RESET FORM

application Group Dental and/or Eye Care Insurance

Ameritas Life Insurance Corp. P.O. Box 81889, Lincoln, NE 68501-1889

Ameritas

See reverse side for additional information

1. **Applicant's Legal Name** _____

2. **Doing business as** _____

3.

_____
P.O. Box / ZIP Code

_____
Street Address

_____
City / State / ZIP

_____
Phone No. Fax No.

_____
E-mail Address Tax I.D. No.

4. **What is the nature of your business or industry?**

_____

5. **Eligibility**

Total Number of Eligible Employees . . . . . _____

Employees in Waiting Period . . . . . _____

6. **Are any classes or locations excluded?** . . . . . ☐ Yes ☐ No

Are domestic partners included? . . . . . ☐ Yes ☐ No

Are retirees included? . . . . . ☐ Yes ☐ No

(If yes, please use reverse side for explanation.)

7. **Are any subsidiary and/or affiliated companies to be insured?** . . . . . ☐ Yes ☐ No

(If yes, please use reverse side to list name and location.)

8. **How many hours per week equals full time employment?** . . . . . _____

9. **Employee Participation**

Employer contributes _____% of employee premium.

☐ **Tied-to-Medical** (All employees covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all employees must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

10. **Dependent Participation:**

Employer contributes _____% of dependent premium.

☐ **Tied-to-Medical** (All eligible dependents covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All eligible dependents must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all eligible dependents must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

11. **Section 125 Plan**

Election Period _____

Plan Year _____

12. Employee welfare benefit plans that are subject to ERISA must satisfy various reporting, disclosure and related obligations. These requirements include the provisioning of a Summary Plan Description or SPD. The certificate of coverage can serve as an SPD if certain information is additionally disclosed. Please check one of the following (failure to respond shall be considered a positive response for A. and a negative response for B.).

A. ☐ **Plan is subject to ERISA (complete question 12.B.)**

☐ **Plan is NOT subject to ERISA — Church or Govt. employer or other safe-harbor exception** (see DOL Reg. §2510.3-1(j))

B. ☐ **Applicant requests that Ameritas Life Ins. Corp. prepare a SPD for its dental and/or vision plan** . . . . . ☐ Yes ☐ No

If yes, the company is to prepare a SPD. The following information is required under ERISA and MUST be included in the SPD.

Plan No. _____ Plan Fiscal Year End Date _____

Plan Administrator:

Name: _____

Address: _____

City, State, ZIP _____

Phone No. _____ Plan Fiscal Year _____

Please Note: Applicant remains responsible for **ensuring** that SPD form provided by Ameritas Life Insurance Corp. is complete and accurate and satisfies applicable laws and regulations. Moreover, applicant remains responsible for providing its plan participants with SPD updates as required by applicable law and regulations.

13. Waiting Period

_____ for those employed on or before the policy effective date.

_____ for those employed after the new policy effective date.

☐ month(s) ☐ calendar days ☐ working days

14. Effective Date and Termination Date

☐ Immediate

☐ First of Month Effective date / End of Month Termination date

☐ Other

15. Premium Payment Mode (In advance)

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ Payroll Deduction (To choose this option, employee must pay employee and dependent premium.)

If policy effective date is other than first of the month, is a first of the month premium due date desired? . . . ☐ Yes ☐ No

Billing Options

☐ Home Office ☐ Third-Party Administration

_____
Contact Name

_____
Title

_____
Street Address

_____
City / State / ZIP

_____
Phone No. Fax No.

_____
E-mail Address

16. The following coverages are applied for:

Employee & Dependents Benefits

☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

Employee Only Benefits

☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

This insurance shall be effective on: _____
(Premiums due prior to the coverage period.)

17. Policy and Certificate Delivery (select one)

A. eCert*/ePolicy (*generic cert, non-personalized)

☐ via PDF format sent via e-mail to:

_____

☐ via eService and member portal

B. Paper policy/personalized certificates

☐ Initial employees only

☐ Subsequently added employees

Note: eCert will be available on member portal for all members.

18. Insurance requested on this application will replace the coverage(s) checked.

Coverages: ☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

Name of Current Carrier _____

Policy No. _____

☐ Coverage applied for is replacing comparable coverage now or previously in force with another carrier.

_____
Termination Date Original Effective Date

Item 6: Exclusions

a. Classes, include reason for exclusion.

b. Locations, if location is different from applicant's, list city and state.

Item 7: Subsidiary and/or affiliated companies to be insured. List names and locations.

Plan Design and Proposed Rates:

Additional Remarks:

Agreements

This application will be subject to review and approval by the Home Office of Ameritas Life Insurance Corp. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Ameritas Life Insurance Corp., group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

Statements

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. (See state-specific statements.)

Note for Maryland Insureds: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ **If you do not want your company name used by Ameritas Life Insurance Corp. in our effort to recruit Network providers, check this box.**

Signed at: City_____ State_____ Date_____

Signed by: (Policyholder Representative)

Printed name and title _____

Signature _____

Soliciting Agent: I understand and agree that if I'm not already appointed with Ameritas Life Insurance Corp., I must apply to and be appointed with Ameritas before I present this product to any client.

Printed Name_____

Signature _____

The policy provides dental and/or vision benefits only. Review your policy carefully.

Was a binder check received? ☐ Yes ☐ No If yes, then amount $_____.

Check received by (agent)_____ **Authorized by** (policyholder)_____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERITAS LIFE INSURANCE CORP.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Electronic Delivery Terms and Disclosures

Ameritas Life Insurance Corp. ("Company") P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax 402-467-7338

Ameritas Life Insurance Corp. ("Ameritas", "we", "our", or "us") is required by law to provide its policyholder ("policyholder" or "you") with certain documents related to your policy with us. In order to streamline how you do business with us, we are providing you with the option to receive the following documents electronically. These documents may include the following:

- Policy(s) documents, forms, endorsements, and certificates
- Policyholder notices
- Renewal notices
- ID Cards
- Lapsed Payment notice
- Policyholder or member related communications

By selecting electronic delivery on the application, you give us your consent to allow Ameritas to deliver all documents relating to your insurance policy(s) electronically. This consent for electronic delivery is effective until you withdraw it all or in-part through the method described below.

The delivery of insurance related documents to you electronically rather than sending paper copies shall not affect the validity, legal effect or enforceability of such insurance related documents.

Method of Delivery

We may make electronic documents available to you and/or your plan members by posting them to a secure portal website, or we may send them via email to the email address that you and/or your plan members provide to us. In some unique circumstances, we may also send paper copies of documents to you and/or your plan members, even though we have provided them to you electronically.

Request for Paper Copy

You may request a paper copy of any required policy document that was originally provided to you electronically. To request a copy of any document provided electronically please send us a request through one of the methods below. Include your policy number and the particular notice or document you are requesting.

Mail: Ameritas Group Administration
5900 O Street
Lincoln, NE 68510

Email: group_assistants@ameritas.com

Phone: 1-800-659-2223

Withdrawal of Consent

You may withdraw your consent to electronic delivery by providing written notice to us at any time. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

Updating Contacts

You are responsible for providing us with updated information on how we may contact you electronically should your information change from what was previously provided. To update your information, please contact us by one of the methods listed above.

Hardware and System Requirements

To ensure delivery of your policy documents, it requires a computer with the following minimum hardware and system requirements necessary to sign, print, retain and receive such documents.

System	Computer or mobile device with access to the internet and adequate storage available to save and/or print documents
Operating Systems	Microsoft Windows®, MAC OS, Apple iOS, Android (within 2 versions of current)
Browsers	Microsoft Edge, Google Chrome, Firefox (within 2 versions of current); with support for minimum 128-bit SSL encryption enabled
PDF Reader	Acrobat Reader® or similar software to view and print PDF files
Enabled Security Settings	Allow strictly necessary cookies
Email	Email service with valid email account

Terms and Conditions

By selecting electronic delivery on the application, you are confirming that you and/or the affected plan members have a computer or electronic device that meets the system requirements necessary to print, store and receive these documents electronically and that you and/or the affected plan members may be able to access such documents for future reference. Consent does not mean Ameritas must provide documents electronically and Ameritas reserves the right to cancel or no longer provide information electronically to preserve systems or protect data. If we modify these terms, you will receive notice of any modified changes in advance. The modified terms will apply to your insurance policy(s) and be binding on you unless you withdraw your consent utilizing one of the methods listed above. There may be fees associated related to internet service or data limitations that Ameritas is not responsible for. Ameritas may record certain data or metadata related to any transaction or request for history, to resolve disputes, or for other business reasons. This includes but is not limited to: IP address, answers to questions or prompts, mouse clicks, keystrokes, audit trails showing history or requests that may be submitted by the user. Electronic signatures on electronic records submitted to Ameritas Life Insurance or Ameritas Life Insurance of NY by the policyholder or its plan members must comply with all applicable laws and regulations including without limitation to the federal Electronic Signatures in Global and National Commerce Act ("UETA") or similar state electronic signature laws. If a policyholder with a self-funded Plan requests we post self-funded plan documents on the Ameritas website, Ameritas will post as a matter of convenience to the policyholder and does not assume any Plan Administrator duties related to ERISA including the distribution of Summary Plan Descriptions (SPDs) or other ERISA-required reports or disclosures.

For groups choosing electronic delivery.