# application

## for group dental and/or vision insurance

See reverse side for additional information.

AMERITAS LIFE INSURANCE CORP.
Lincoln, NE

**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 _____

**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 Ins. 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.

☐ It is intended that the insurance coverage applied for be in addition to, supplemented by, or supplemental to any similar coverage now in force, or to be in force, with this or any other 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**

We are required to advise you of the following: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties..

☐ **If you do not want your company name used by Ameritas Life Insurance Corp. in our effort to recruit PPO 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.