RESET FORM

application

for Group Dental and/or Vision Insurance Benefits

AMERITAS LIFE INSURANCE CORP.
P.O. Box 81889
Lincoln, NE 68501-1889
855-517-5307 / Fax: 402-467-7338

1. The following coverages are applied for:
   Employee & Dependents Benefits ☐ Dental ☐ Orthodontia ☐ Vision ☐ Other _____
   Employee Only Benefits ☐ Dental ☐ Orthodontia ☐ Vision ☐ Other _____
2. Group Name _____
   Doing business as _____ Tax I.D. Number _____
3. Group Address: Street or P.O. Box _____
   City _____ State _____ ZIP code _____
4. Group Contact: _____ Telephone # ( ) _____ Fax # ( ) _____
5. Type of business _____
6. Payment mode ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually
7. Total Employees Eligible. . . . . _____
8. Number of Employees Enrolled . . . _____
9. It is requested that this insurance be effective on _____. (The effective date must be the first of the month. All papers must be received by the Company in acceptable form by the requested effective date.)
10. All present employees are to be eligible on the effective date except part-time employees and those on disability leave. Employees who come to work after the effective date shall be eligible on the first day of the month following completion of _____ (☐ days or ☐ months) of continuous active service.
    Every group will have an open enrollment period, which is the group's policy anniversary date unless otherwise changed.
11. The firm will pay _____% of all employee costs and _____% of dependent costs.
12. I hereby represent that there are, as of this date, a total of _____ full-time eligible employees including owners, partners, and officers in the employment of this firm. If any class or classes of employees are to be excluded from eligibility, describe them briefly.

    _____
    (Such class exclusion must be nondiscriminatory.)
13. 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 and/or ☐ Subsequently added employees
    Note: eCert will be available on member portal for all members.
14. Will the insurance requested on this application replace the coverage(s) checked? ☐ Yes ☐ No
    Coverages: ☐ Dental ☐ Orthodontia ☐ Vision ☐ 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 _____
15. Section 125 Plan: Election Period _____ Plan Year _____

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.

– over –

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 California Residents: Any false statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For group policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-2797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Note for Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico and Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for 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 Texas Residents: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Note for Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

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

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

Dated at _____ this _____ day of _____, 20___
City / State

Signature of Applicant X _____ Date _____

Printed Name of Applicant _____ Title _____

Signature of Licensed Agent X _____ Agent License I.D. # _____

Printed Name of Writing Agent _____ Agent # _____

All insurance plans may not be available in all states. Check with our administrative office.