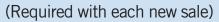
## new business transmittal



## Send all enrollment material to:

P.O. Box 81889 / Lincoln, NE 68501-1889 / 855.517.5307 / Fax: 402.467.7338

Home	Office use only
Group #	

Writing Agent Information (please	print)				
Writing Agent		Agent C	Code #	D	Date
Address					
City		State		ZIP code	
Phone Number	Fax Number		E-mail		
Splitting Agent		Agent Code #		Commission	n Split % %
If applicable: AFLAC Agent Code #		Colonial Agent	Code #		
Group Information (please print)	□ New □ Ad	Iditional Accoun	t		
Name of Company/Group					Desired Effective Date
Billing Address					(1st of month only)
City	State	:	ZIP code		
Group Contact Name		em	nail		
Phone Number ( )		Fax Num	ber ( )		
Eligible Employees: Full-Time defined as	hours Are Pa	art-Time employee	s eligible?	Yes No If Y	es, defined as hours
Are Domestic Partners included?   Yes	□ No				
Employee Effective Date and Termination	Date: Immedia	te 🗌 First-of-Moi	nth Effective D	ate / End-of-Mor	nth Termination Date
Who is paying the premium?   Employe	ee 🗌 Employer	If quoted, please p	orovide quote	# sold	
Must all employees covered on the employees	yer's medical plan l	be insured? 🗌 Ye	es 🗌 No		
If employer pays premium, will those cover	ered elsewhere be a	llowed to waive co	verage? 🗌 Y	es No	
Cash with applications: Total \$		(Include \$10 bi	lling fee, if app	olicable.)	
<b>Group Dental Insurance</b>					
<ul><li>□ EDGE PREMIER</li><li>□ EDGE PLUS</li><li>□ UNIQUE EDGE</li><li>□ SIMPLE EDGE</li></ul>	☐ IMMEDIATE E☐ TWO TIER ED	_	EDGE PLUS OGE	□ NO DEDUCT	TIBLE PREMIER
# of enrollment cards attached		Area Rating			
☐ With Orthodontia ☐ Without Orthodo	ntia 🗌 Waive the N	Missing Tooth Clau	se 🗌 Increas	se Benefit Maxim	nums
Takeover requested? Yes No		-			
<ul><li>☐ This plan replaces existing coverage at</li><li>☐ Section 125. If the dental or vision and Section 125.</li></ul>				u wish the dental (	or vision coverage to renew:
	cases, this may be a		•		<u> </u>
I sold the following dental rates:				J	
☐ Plan A: Employee Only: \$	Employee &	1 Dependent: \$		Employee & Fa	mily: \$
☐ Plan B: Employee Only: \$	Employee &	1 Dependent: \$		Employee & Fa	mily: \$
☐ Plan C: Employee Only: \$	Employee &	1 Dependent: \$		Employee & Fa	mily: \$

- over -

Vision Insurance							
☐ Edge Vision (VSP)							
# of enrollment cards attached	☐ Option 1 12-12-24 ☐ Option 2 12-12-12						
☐ Plan A: Employee Only: \$	Employee & 1 Dependent: \$	Employee & Family: \$					
☐ Plan B: Employee Only: \$	Employee & 1 Dependent: \$	Employee & Family: \$					
☐ Vision Perfect Increasing Flat Max	# of enrollment cards attached						
☐ Not Voluntary: Employee Only: \$	Employee & 1 Dependent: \$	Employee & Family: \$					
☐ Voluntary: Employee Only: \$	Employee & 1 Dependent: \$	Employee & Family: \$					
Additional Information							
Agent Signature	Da	ate					

## **Important Notice**

All products are not approved in all states. Please check with the home office for product approval information in your state or check our Web Site: www.ameritasgroup.com/edge