new business transmittal

(Required with each new sale)

AMERITAS LIFE INSURANCE CORP.

Home Office use only	
Group #	

Send all enrollment material to:
P.O. Box 81889 / Lincoln, NE 68501-1889 / 855.517.5307 / Fax: 402.467.7338

Writing Agent Information (please print)

Writing Agent _____ Agent Code # _____ Date _____

Address _____

City _____ State _____ ZIP code _____

Phone Number _____ Fax Number _____ E-mail _____

Splitting Agent _____ Agent Code # _____ Commission Split _____ % _____ %

If applicable: AFLAC Agent Code # _____ Colonial Agent Code # _____

Group Information (please print) ☐ New ☐ Additional Account

Name of Company/Group _____

Billing Address _____

City _____ State _____ ZIP code _____

Desired Effective Date (1st of month only) _____

Group Contact Name _____ email _____

Phone Number ( ) _____ Fax Number ( ) _____

Eligible Employees: Full-Time defined as _____ hours Are Part-Time employees eligible? ☐ Yes ☐ No If Yes, defined as _____ hours

Are Domestic Partners included? ☐ Yes ☐ No

Employee Effective Date and Termination Date: ☐ Immediate ☐ First-of-Month Effective Date / End-of-Month Termination Date

Who is paying the premium? ☐ Employee ☐ Employer If quoted, please provide quote # sold _____

Must all employees covered on the employer's medical plan be insured? ☐ Yes ☐ No

If employer pays premium, will those covered elsewhere be allowed to waive coverage? ☐ Yes ☐ No

☐ Cash with applications: Total $ _____ (Include $10 billing fee, if applicable.)

Group Dental Insurance

☐ EDGE PREMIER ☐ EDGE PLUS ☐ IMMEDIATE EDGE ☐ BASIC EDGE PLUS ☐ NO DEDUCTIBLE PREMIER
☐ UNIQUE EDGE ☐ SIMPLE EDGE ☐ TWO TIER EDGE ☐ MAC EDGE

# of enrollment cards attached _____ **Area Rating** _____

☐ With Orthodontia ☐ Without Orthodontia ☐ Waive the Missing Tooth Clause ☐ Increase Benefit Maximums

Takeover requested? ☐ Yes ☐ No

☐ This plan replaces existing coverage and "takeover" benefits are not requested.

☐ Section 125. If the dental or vision and Section 125 renewal dates are different, indicate when you wish the dental or vision coverage to renew:

_____ *(In some cases, this may be authorization to waive the 12 month rate guarantee.)*

I sold the following dental rates:

☐ Plan A:	Employee Only: $ _____	Employee & 1 Dependent: $ _____	Employee & Family: $ _____
☐ Plan B:	Employee Only: $ _____	Employee & 1 Dependent: $ _____	Employee & Family: $ _____
☐ Plan C:	Employee Only: $ _____	Employee & 1 Dependent: $ _____	Employee & Family: $ _____

– 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 Date

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