Dental and Vision Enrollment Form

Insured by Ameritas Life Insurance Corp.

AMERITAS LIFE INSURANCE CORP.
P.O. Box 81889
Lincoln, NE 68501-1889
800-659-2223 / Fax: 402-467-7338

Administered by HealthPlan Services

Current member of AVMA ☐ Yes ☐ No Current employee of an AVMA member ☐ Yes ☐ No

AVMA membership number _____ (required for all applicants)

Enroll in ☐ Dental Select Plan: ☐ High ☐ Low ☐ Vision Select Plan: ☐ High ☐ Low

Applicant Information

Marital Status ☐ Single ☐ Married ☐ Civil Union (as defined by state law or your Group) ☐ Domestic Partner (as defined by state law or your Group)

Social Security number _____ E-mail address _____

Primary Applicant's last name, first name, MI _____

Date of birth _____ ☐ Male ☐ Female Phone number ( )

Full time date of hire _____ Requested effective date ____/____/____

Occupation _____

Hours worked each week _____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address _____ City _____ State _____ ZIP _____

Are you covered under another dental insurance plan?..... Applicant: ☐ Yes ☐ No Dependents: ☐ Yes ☐ No

Are you covered under another vision insurance plan? ..... Applicant: ☐ Yes ☐ No Dependents: ☐ Yes ☐ No

Is your employer contributing to your premium? ☐ Yes ☐ No If yes, Employer name _____

Employer street address _____ City _____ State _____ ZIP _____

Dependent Coverage Information

List all eligible dependents to be added. (Applicant must be enrolled to cover dependents)

print full legal name (last, first, MI)	dental add	vision add	relationship	sex	date of birth	social security no.
1						
2						
3						
4						
5						

Requested Payment Method

☐ Monthly EZ Pay – ONE MONTH PREMIUM REQUIRED (No administration fee) Complete EZ Pay agreement below.
☐ Monthly Direct Billing Option – ONE MONTH PREMIUM REQUIRED ($3 per person, up to $15 maximum administration fee)
☐ Quarterly Direct Billing Option – THREE MONTHS PREMIUM REQUIRED ($8 per quarter administration fee)
☐ Semi-Annual Direct Billing Option – SIX MONTHS PREMIUM REQUIRED ($8 semi-annual administration fee)

Total payment including administration fee with application required. Make checks payable to: Ameritas Life Insurance Corp.

If requesting EZ Pay, complete the EZ Pay Agreement. (Only available if employer is NOT contributing premium.)

_____
Payor Name or Depositor if different Relationship to Applicant

Name of Financial Institution _____ Account number _____

Financial Institution Address _____ City _____ State _____ ZIP _____

Specify Type of Account ☐ Checking ☐ Savings

ABA 9 Digit Routing Number (See below or please call your financial institution for assistance) _____

Ameritas and/or HealthPlan Services, acting as Plan Administrator on behalf of Ameritas, is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month, until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Certificate is not issued. ν I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by HealthPlan Services, and I agree that the bank named shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Ameritas and/or HealthPlan Services in writing.

X _____
Primary Payor Signature Date

Joe Smith
123 Main Street
Anytown, IL 12345

ATTACH YOUR INITIAL CHECK OR MONEY ORDER FOR PREMIUM PAYMENT

Date _____

Pay to the order of **AMERITAS LIFE INSURANCE CORP.** $ _____
Dollars

For _____

ROUTING NUMBER 123456789 1234567891011 1117

EZ PAY PLAN APPLICANTS ONLY

VOIDED CHECK

DEPOSIT SLIPS ARE NOT ACCEPTABLE

please sign (applicant) The certificate provides dental and vision benefits only. Review your certificate carefully.
As a member/employee, I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____

Applicant's Signature (do not print) Date State Where Signed

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.

Soliciting producer name _____

X _____

Soliciting Producer's Signature Date

Once completed, signed and dated, mail this form along with your premium payment to:
AVMA Life C/O HealthPlan Services, P.O. Box 30474, Tampa, FL 33630-3474, Phone:
800-621-6360