

# Dental and Vision Enrollment Form



Insured by Ameritas Life Insurance Corp.

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

Administered by HealthPlan Services

## Applicant Information

Marital Status  Single  Married  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.	college student?
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. 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

Note for 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.

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