GemStar℠ Elite Dental 1000+

Group dental coverage you can smile about.

Employees value benefits that help them pay for the care they and their families need to stay healthy. And when you offer incentives, you see the value too.

- For employer groups with 5-99 lives
- Access to nationwide savings with Ameritas Dental Network
- Featuring Dental Rewards®

GR 6916 5-17

Ameritas
fulfilling life.

Dental Network

The GemStar Elite plan is designed for those who value the freedom to use any dentist. However, if you visit an Ameritas dental network provider your out-of-pocket costs almost always will be less. That's because plan-paid benefits are based on a negotiated Ameritas fee schedule. If you use a non-network dentist, plan-paid benefits are based on the 90th percentile of the usual and Customary charges, which may result in higher out-of-pocket costs compared to the Ameritas contracted fee schedule.

Features of the Ameritas dental network include:

- Discounted fees, typically 30% below average charges in your community
- Immediate network discounts
- One of the largest nationwide networks with other 400,000 access points and over 100,000 unique providers.

You have the option of a Network (MAC/MAB) or U&C PPO dental plan. If you visit an Ameritas dental network provider, the plan-paid benefits are based on a contracted fee schedule.

Visit **star.ameritas.com/findadentist** to search for network providers.

Network not available in MT, RI and the PA counties of Forest and Potter.

Plan Details

	Plan Benefit*
Preventive (type 1) • exams/cleanings (two per year) • all X-rays are covered under preventive • fluoride treatment (under age 16) • sealants (under age 16)	**100% day one**
Basic (type 2) • fillings • simple extractions • surgical endodontics • periodontal procedures	**80% day one**
Major (type 3) • oral surgery • crowns • bridges • dentures	**50% after year one** 50% day one for groups with 25+ lives enrolled or existing coverage
Orthodontia (under age 19) • $1,000 lifetime maximum per child	**50% after year one** 50% day one for groups with existing coverage
Annual Deductible Waived for preventive; per person for basic and major services combined, with a maximum of three deductibles per family	**$50**
Annual Maximum Benefit Per person for preventive, basic and major services combined	**$1,000** 1000 CYM w/1500 buy-up option

Groups with 24 lives or less that have existing coverage will receive takeover credit. Please refer to the Policy or Certificate of Insurance for a complete list of covered procedures and limitations.

* When you visit an Ameritas Dental Network provider, Ameritas sends payment directly to the provider. There is no balance billing – you won't pay the difference between the dentist's contracted fee and what the plan allows, subject to contractual limitations. When you visit an out-of-network dentist, you must pay the difference between what the plan pays and the dentist's actual charge and may have to submit your own claim.

Member Savings

You may receive additional savings that can reduce out-of-pocket expenses:

Save up to 15% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide (savings does not include contact lenses or vision care materials).

Save on prescription medications through any Walmart or Sam's Club pharmacy (membership at Sam's Club not required).

Access to emergency vision provider referrals when traveling outside the U.S. through AXA Assistance.

Dental Rewards

Seeing the dentist at least once a year is a great dental health habit. Our program rewards you when you visit the dentist yearly, but don't wind up using all of your annual maximum benefit in any given year.

Unlike the "use it or lose it" approach, you can carry over part of your unused benefit so the money is there when you need it the most. You can keep building your reward until you reach the maximum accumulation of $1,000.

How it works:

1. Submit at least one dental claim a year.
2. Keep your total benefits received for that year at or below the plan's annual threshold amount. $500 for $1,000 or $750 for $1,500 Annual Maximum.
3. Earn reward to use for the following year.

Earn an additional PPO Bonus when you visit an Ameritas Dental Network provider.

Dental Rewards Sample Bonus		
Annual maximum for Preventive, Basic and Major services	$1,000	$1,500
Dental Reward carryover	+ $250	+ 250
PPO Bonus	+ $100	+ $150
Next year's annual maximum	**$1,350**	**$1,900**

PPO Bonus is not available in MT or RI.

Additional Information

Out-of-network benefits are based upon the 90th percentile usual and customary fees charged in the area where service is rendered (percentile may be higher according to state requirements).

Eligible Employees: An individual employed by a participating employer who works 20 hours or more per week, and who is considered an employee for Social Security purposes. Partners and Proprietors are also considered to be eligible employees.

Dependents: A spouse or domestic partner, or dependent child under age 26.

Eligible Dependent: An unmarried child at least 26 years of age who relies on you for support because he or she is incapable of self-sustaining employment due to mental or physical incapacity.

Alternative Procedures: If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate procedure is available. Accordingly, the plan member may choose to apply the alternate benefit amount determined under this provision toward payment to the submitted treatment.

What is not Covered?

Covered Expenses will not include and benefits will not be payable for expenses incurred:

- for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.
- for any procedure begun before the insured person was covered under this contract.
- for appliances, restorations, or procedures to:
  - alter vertical dimension;
  - restore or maintain occlusion; or
  - splint or replace tooth structure lost as a result of abrasion or attrition.
- for any procedure begun after the insured person's insurance under this contract terminates.
- to replace lost or stolen appliances.
- for any treatment which is for cosmetic purposes.
- for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)
- for orthodontic treatment under the following provisions:
  - for treatment begun on or after the insured's 19th birthday;
  - for treatment begun before the insured became covered under this section;
  - before the insured has been insured under this section for at least 12 consecutive months (except in VT);
- for which the insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit. Except in CA and KY.
- for charges which the Insured person is not liable or which would not have been made had no insurance been in force.
- for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.
- because of war or any act of war, declared or not.
- for dependents under age 19 if the policyholder has purchased such coverage under a separate essential health benefits package or stand- alone pediatric essential oral health services policy.

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Product not available in Connecticut, Illinois, New York, Vermont, and Washington.

This information is provided by Ameritas Life Insurance Corp. (Ameritas Life). Group dental, vision and hearing care products (9000 Rev. 03-16, dates may vary by state) and individual dental and vision products (Indiv. 9000 Ed. 07-16, dates may vary by state) are issued by Ameritas Life. Some plan designs are not available in all areas. Some states require that producers be appointed with Ameritas Life before soliciting its products.

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GemStar Elite Dental 1000+

Rates effective *August 1, 2016*

Use the following to find your monthly dental rates by Area and network coverage.

Find your Area by locating the first 3 digits of your zip code

State	Zip	Area
Alabama	350-355, 359	3
	All Other	1
Alaska	995-996	8
	All Other	6
Arizona	856-857, 864	2
	All Other	1
Arkansas	All	1
California	956-958	4
	917-918, 935-938, 943-948 952, 955, 959-960	5
	900-905, 913-914, 931	7
	915-916	8
	All Other	6
Colorado	800-806, 808-809	4
	All Other	2
Connecticut	060-065, 067	4
	All Other	5
Delaware	All	3
D.C.	All	6
Florida	320, 322, 326-329 338, 344, 347	1
	330-332	5
	334	4
	All Other	3
Georgia	301-303, 305-307, 311, 399	2
	300	3
	All Other	1
Hawaii	All	4
Idaho	832, 834	1
	All Other	2
Illinois	604, 610-611, 616-618, 627	2
	600-603, 605	3
	606-608	4
	All Other	1
Indiana	460, 462-468, 475-477	2
	473	3
	All Other	1
Iowa	500-502, 508, 515	1
	All Other	2
Kansas	660-661	2
	662	3
	All Other	1
Kentucky	All	1
Louisiana	707-711	2
	712	3
	All Other	1
Maine	047	1
	All Other	2
Maryland	206-207, 209-211	2
	217	3
	All Other	4
Massachusetts	017, 019, 025, 026	6
	All Other	5
Michigan	485	1
	480-481, 483, 488-489	3
	All Other	2
Minnesota	553-555, 557-558, 564	3
	All Other	2
Mississippi	390-392	2
	All Other	1
Missouri	631, 640-649, 651-652	2
	All Other	1
Montana	590-591	2
	598	4
	All Other	3
Nebraska	685, 691	2
	All Other	1
Nevada	890-891	2
	889, 893	4
	897	5
	All Other	6
New Hampshire	032-037	4
	All Other	5
New Jersey	070, 074, 076, 078-079 085-086, 088	5
	All Other	4
New Mexico	881	2
	882	5
	All Other	1
North Carolina	278-279, 283	1
	277, 286, 288	3
	All Other	2
North Dakota	581	3
	All Other	2
Ohio	452	2
	All Other	1
Oklahoma	740-743	2
	All Other	1
Oregon	978	2
	977	4
	All Other	3
Pennsylvania	170-178, 182-187, 189, 193-194	2
	190-192	3
	All Other	1
Rhode Island	All	3
South Carolina	292	2
	All Other	1
South Dakota	572-573	3
	All Other	1
Tennessee	373-374	2
	All Other	1
Texas	756-757, 776-777	1
	750-753	3
	754	4
	All Other	2
Utah	All	2
Vermont	Not Available	
Virginia	224-225	1
	229-232, 240-244	2
	228	3
	226-227, 238-239, 245-246	4
	222-223	6
	All Other	5
Washington	Not Available	
West Virginia	262-265	3
	255-257	4
	All Other	2
Wisconsin	All	2
Wyoming	All	2

MY AREA NUMBER

Find your Dental Rate by your Area and Annual Maximum

Rates for $1000 Annual Max									**DENTAL RATE**
Area:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	***per employee***
Employee Only	$31.81	$34.87	$38.32	$42.15	$46.37	$50.97	$55.95	$61.70	
Employee + Spouse	$64.88	$71.13	$78.17	$85.99	$94.59	$103.97	$114.13	$125.85	
Employee + Child(ren)	$68.33	$74.92	$82.33	$90.56	$99.62	$109.50	$120.20	$132.55	
Employee + Family	$110.78	$121.46	$133.47	$146.82	$161.50	$177.52	$194.87	$214.89	

Rates for $1500 Annual Max									**DENTAL RATE**
Area:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	***per employee***
Employee Only	$34.83	$38.18	$41.96	$46.16	$50.77	$55.81	$61.26	$67.56	
Employee + Spouse	$71.05	$77.90	$85.60	$94.16	$103.58	$113.85	$124.98	$137.82	
Employee + Child(ren)	$74.83	$82.05	$90.16	$99.18	$109.09	$119.91	$131.63	$145.16	
Employee + Family	$121.30	$133.00	$146.15	$160.77	$176.84	$194.38	$213.38	$235.30	

Find the Monthly Dental Premium for your group

	Dental Rate	**# of Employees**		**Subtotal**
Employee Only	$	x	=	$
Employee + Spouse	$	x	=	$
Employee + Child(ren)	$	x	=	$
Employee + Family	$	x	=	$
Total Monthly Dental Premium for Your Group				$

For groups with 5-99 employees

For groups over 99 eligible employees please request a quote from the home office.

A rate increase of 20% is required for Schools, Government Agencies, Interior Design, Religious or Charitable Organizations, Insurance or Agent Offices, Banks, Law Offices, Jewelry Stores, and Real Estate Sales.

GemStar Sold Case Submission
Ameritas Life Insurance | Lincoln, NE 68501

Email completed worksheet, Employer Application and Employee Enrollment Forms to:
GemStarBrochure@ameritas.com

Questions? Call 402-309-2032

TO BE COMPLETED BY WRITING AGENT				
Group Information				
Group Name			Telephone Number	
Address	City		State	Zip
Effective Date	Total Eligible Lives		Takeover ☐ Yes ☐ No	
Elite Dental				
Dental Plan ☐ 1500 ☐ 1000+	ER Contribution for EE Only $		Total Enrolled Lives	
Sold Rates:	Employee $	Employee + Spouse $	Employee + Child(ren) $	Employee + Family $
Flex Vision				
Vision Plan ☐ VSP ☐ EyeMed ☐ Non-Network	ER Contribution for EE Only $		Total Enrolled Lives	
Sold Rates:	Employee $	Employee + Spouse $	Employee + Child(ren) $	Employee + Family $
Writing Agent Information				
Name	Telephone Number			
Agency Name (if applicable)				
Appointed with Ameritas? ☐ Yes ☐ No, If no, appointment forms are attached				
TO BE COMPLETED BY GENERAL AGENT				
GA Name	Telephone Number			
GA Agency Name (if applicable)				
Commissions: Writing Agent %	| Other %	| GA %		
WRITING AGENT/GENERAL AGENT SPECIAL INSTRUCTIONS OR NOTES				
AMERITAS USE ONLY:				
Ameritas Sales Representative:				
Special Instructions or Notes:				
Completed By	Date			

RESET FORM

application Group Dental and/or Eye Care Insurance

Ameritas Life Insurance Corp. P.O. Box 81889, Lincoln, NE 68501-1889

Ameritas

See reverse side for additional information

1. **Applicant's Legal Name** _____

2. **Doing business as** _____

3.

_____
P.O. Box / ZIP Code

_____
Street Address

_____
City / State / ZIP

_____
Phone No. Fax No.

_____
E-mail Address Tax I.D. No.

4. **What is the nature of your business or industry?**

_____

5. **Eligibility**

Total Number of Eligible Employees . . . . . _____

Employees in Waiting Period . . . . . _____

6. **Are any classes or locations excluded?** . . . . . ☐ Yes ☐ No

Are domestic partners included? . . . . . ☐ Yes ☐ No

Are retirees included? . . . . . ☐ Yes ☐ No

(If yes, please use reverse side for explanation.)

7. **Are any subsidiary and/or affiliated companies to be insured?** . . . . . ☐ Yes ☐ No

(If yes, please use reverse side to list name and location.)

8. **How many hours per week equals full time employment?** . . . . . _____

9. **Employee Participation**

Employer contributes _____% of employee premium.

☐ **Tied-to-Medical** (All employees covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all employees must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

10. **Dependent Participation:**

Employer contributes _____% of dependent premium.

☐ **Tied-to-Medical** (All eligible dependents covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All eligible dependents must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all eligible dependents must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

11. **Section 125 Plan**

Election Period _____

Plan Year _____

12. Employee welfare benefit plans that are subject to ERISA must satisfy various reporting, disclosure and related obligations. These requirements include the provisioning of a Summary Plan Description or SPD. The certificate of coverage can serve as an SPD if certain information is additionally disclosed. Please check one of the following (failure to respond shall be considered a positive response for A. and a negative response for B.).

A. ☐ **Plan is subject to ERISA (complete question 12.B.)**

☐ **Plan is NOT subject to ERISA — Church or Govt. employer or other safe-harbor exception** (see DOL Reg. §2510.3-1(j))

B. ☐ **Applicant requests that Ameritas Life Ins. Corp. prepare a SPD for its dental and/or vision plan** . . . . . ☐ Yes ☐ No

If yes, the company is to prepare a SPD. The following information is required under ERISA and MUST be included in the SPD.

Plan No. _____ Plan Fiscal Year End Date _____

Plan Administrator:

Name: _____

Address: _____

City, State, ZIP _____

Phone No. _____ Plan Fiscal Year _____

Please Note: Applicant remains responsible for **ensuring** that SPD form provided by Ameritas Life Insurance Corp. is complete and accurate and satisfies applicable laws and regulations. Moreover, applicant remains responsible for providing its plan participants with SPD updates as required by applicable law and regulations.

13. Waiting Period

_____ for those employed on or before the policy effective date.

_____ for those employed after the new policy effective date.

☐ month(s) ☐ calendar days ☐ working days

14. Effective Date and Termination Date

☐ Immediate

☐ First of Month Effective date / End of Month Termination date

☐ Other

15. Premium Payment Mode (In advance)

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ Payroll Deduction (To choose this option, employee must pay employee and dependent premium.)

If policy effective date is other than first of the month, is a first of the month premium due date desired? . . . ☐ Yes ☐ No

Billing Options

☐ Home Office ☐ Third-Party Administration

_____
Contact Name

_____
Title

_____
Street Address

_____
City / State / ZIP

_____
Phone No. Fax No.

_____
E-mail Address

16. The following coverages are applied for:

Employee & Dependents Benefits

☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

Employee Only Benefits

☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

This insurance shall be effective on: _____
(Premiums due prior to the coverage period.)

17. 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

☐ Subsequently added employees

Note: eCert will be available on member portal for all members.

18. Insurance requested on this application will replace the coverage(s) checked.

Coverages: ☐ Dental ☐ Orthodontia ☐ Eye Care

☐ 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

Item 6: Exclusions

a. Classes, include reason for exclusion.

b. Locations, if location is different from applicant's, list city and state.

Item 7: Subsidiary and/or affiliated companies to be insured. List names and locations.

Plan Design and Proposed Rates:

Additional Remarks:

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.

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: 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 Insureds: 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 Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

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, D.C. 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 fines and confinement in prison.

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.

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

Signed at: City_____ State_____ Date_____

Signed by: (Policyholder Representative)

Printed name and title _____

Signature _____

Soliciting Agent: I understand and agree that if I'm not already appointed with Ameritas Life Insurance Corp., I must apply to and be appointed with Ameritas before I present this product to any client.

Printed Name_____ For FL agents only, provide FL license #_____

Signature _____

The policy provides dental and/or vision benefits only. Review your policy carefully.

Was a binder check received? ☐ Yes ☐ No If yes, then amount $_____.

Check received by (agent)_____ **Authorized by** (policyholder)_____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERITAS LIFE INSURANCE CORP.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

CLEAR FORM

Authorization Agreement for Electronic Funds Transfer

Ameritas Life Insurance Corp.

Ameritas

Section 1

Provider Name _____

Section 2

Provider Federal Tax Identification (TIN) _____

National Provider Identifier (NPI) _____

Section 3

Provider Contact Name _____ Email Address _____

Telephone Number _____ Fax Number _____

Section 4

I authorize **AMERITAS LIFE INSURANCE CORP.** (hereinafter the Company) to initiate deposit of funds into my checking/savings account indicated below, and the named financial institution below to post the same to such account.

Financial Institution Name _____

Street _____

City _____ State/Province _____ ZIP Code/Postal Code _____

Financial Institution Routing Number _____

Type of Account at Financial Institution (check one) ☐ Checking ☐ Savings

Provider's Account Number with Financial Institution _____

Account Number Linkage to Provider Identifier (TIN) _____

Section 5

Reason for Submission ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

Authorized Signature _____

PLEASE ATTACH A VOIDED CHECK. FOR SAVINGS ACCOUNT ONLY ATTACH A DEPOSIT SLIP. After receiving a completed authorization agreement, it may take up to 30 days to begin making electronic funds transfers.

Disclosure

This authority is to remain in full force and effect until the company has received a written termination notification from me. Said written termination notification must set out an effective termination date and must be received by the company 30 days prior to the set termination date. In no event shall the termination be effective with respect to entries processed by the company prior to the termination date set out in said notification. In the event the depository institution account has been inactive for one year, the arrangement will be stopped and a new authorization agreement must be submitted to the company. In the event the provider's office has a partnership, it is the office's responsibility to notify the company of changes to the partnership.

I further authorize the company to initiate such debit entries to said account as may be necessary to correct any erroneous credit entries previously initiated thereto. I authorize the aforesaid depository institution to accept and to credit or debit the amount of such entries to my account.

In the event that I identify an erroneous entry, I shall, within fifteen calendar days following the date of which the depository institution sends to me a statement of account or a written notice pertaining to such entry, send to the deposit institution a written notice identifying such entry, stating that such entry was in error and requesting the depository institution to reverse the amount thereof to such account.

I have the right to stop payment of any entry by notification to the depository institution prior to posting the account.

The undersigned hereby agrees that all entries initiated hereunder are to be governed in all respects by the operating rules of the National Automated Clearing House Association (NACHA) as amended by the rules of the Mid-America payment exchange, as now or hereafter in effect, and agrees to be bound thereby.

I understand that the company is providing this electronic funds transfer agreement without charge and, that, the company will not be liable for any claims or damages arising, directly or indirectly, from this deposit arrangement.

tips for filling out this form

How to Speed Processing

Missing or incomplete information will slow down processing. Please complete this form in its entirety.

Mail, fax or email completed Authorization Agreement for Electronic Funds Transfer form, along with a voided check or deposit slip, to:

Ameritas
Attn: EFT Team
P.O. Box 82520
Lincoln, NE 68501

Toll Free: 800-487-5553
Fax: 402-309-2580
Email: group@ameritas.com

Contact your financial institution to arrange for the delivery of the required elements necessary to receive EFT payments.

Promptly inform us of any changes in your banking information. Fax or send changes to the attention of the EFT Team at Ameritas, P.O. Box 82520, Lincoln NE 68501 (fax: 402-309-2580) (email: group@ameritas.com).

We will stop the electronic deposit of funds to your account(s) upon receipt of written notification from you. Notification must be faxed or sent to the attention of the EFT Team at Ameritas, P.O. Box 82520, Lincoln NE 68501 (fax: 402-309-2580) (email: group@ameritas.com).

Call the EFT Team at 800-487-5553 with any questions.

If you are submitting for a corporation or multiple locations:

If you are submitting this form for a corporation or multiple dental office locations, you must provide us with the following information **on your company's stationary:**

A list* of all applicable bank accounts with the following information listed **for each account:**

- Bank account number
- ABA
- Routing number
- Name of bank or financial institution
- Name on bank account
- Name, address and telephone number for each dental office location that will be utilizing electronic funds transfer

*Include your signature on the page with this information.

Please note: We must receive two documents – a completed copy of the Authorization Agreement for Electronic Funds Transfer form and a **signed** copy of the above-mentioned listing of applicable bank accounts on **company stationary.**

To check the status of an EFT payment or your enrollment in EFT, contact us at:

800-487-5553
Monday-Thursday 7 a.m. to 12 a.m. CT
Friday 7 a.m. to 6:30 p.m. CT
Email: group@ameritas.com

Website

Visit ameritas.com to access your secure provider account, verify patient benefits, download forms and more.

Please note, the free software Adobe Reader® is needed to view and print electronic forms.

Electronic Claims and Attachments

We can process electronic claims the same day we receive them. Plus, most software can submit claims and attachments while simultaneously creating accounting records. For more information, please visit the following websites:

- ndedic.org
- ez2000dental.com
- nea-fast.com

Join Our Network

If you're not already part of our network, contact the Provider Relations team at 800.755.8844 to learn more about the benefits of being part of our family. We work hard to build lasting relationships with the providers on our network.

Recovery of Erroneous Payment

If we determine a provider has received an overpayment from us, we undergo a formal review process to verify and determine the overpaid amount. Then, we send the provider a formal letter which includes an explanation and requests the provider send us a check for the specified amount.

CLEAR FORM

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Ameritas

Policy and Div. # **010-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ Eye Care ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

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

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

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

Are you covered under another **eye care** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental add	Dental drop	Eye Care add	Eye Care drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐	☐	☐					☐
2	☐	☐	☐	☐					☐
3	☐	☐	☐	☐					☐
4	☐	☐	☐	☐					☐
5	☐	☐	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), 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 _____ X _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

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. (State-specific statements on back.)

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Note for California Residents: 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 877-233-3797. 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 Insureds: 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 Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

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, D.C. 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 fines and confinement in prison.

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.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number –** to make sure plan members are added to the correct group.
- **Department/Division Numbers –** so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers –** the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date –** needed so the correct effective date is calculated for new members.
- **Class Number –** needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

1) submit clear, legible enrollment forms.
2) underline or circle important information.
3) use blue or black ink.

Don't:

1) submit dark copies as they appear black on imaging.
2) highlight, which blackens the area so it cannot be read.
3) write on the top or bottom margins. This information is not always captured on the image system.