Spirit DENTAL & VISION

New Business Checklist

Please confirm that the following is submitted with all new cases.

- ☐ Completed application for group dental and/or vision insurance
- ☐ Completed addendum
- ☐ Completed employee enrollment forms or census spreadsheet
  (census is preferred for ease of processing)
- ☐ Social Security Numbers are required for all enrollees
  (not required for dependents)
- ☐ Sold Quote with elected plan and rates from directbenefits.com/agents
- ☐ If paying by EFT a copy of a voided check is required

If applicable, please confirm that all of the following documentation is provided prior to coverage on takeover cases:

- ☐ Copy of Prior Carrier's 1-2 page summary of benefits
- ☐ Copy of Prior Carrier's most recent billing statement

Policy Documents Delivery Acknowledgement

ID cards will be mailed to the employer for distribution to employees

After all the information listed above is completed and signed, submit all forms using one of the following

Delivery methods:

Email: agentsupport@directbenefits.com
Fax: 651-649-3502 ATTN: Agent Support

Mail: Direct Benefits, Inc.
7900 International Drive, Suite 1040
Bloomington, MN 55425

DirectBenefits
AN ALERA GROUP COMPANY

Submission Date:
New groups should be received no later than the 12th of the month of efficacy in order to submit to the carrier
(i.e. Feb 1st effective date, please submit to Direct Benefits by Feb 12th).

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 Louisiana 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 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 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. **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does not satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

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 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 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.

EFT Form

electronic funds transfer

PO Box 81889 / Lincoln, NE 68501
phone 800.659.2223 / fax 402.467.7338

AMERITAS® LIFE INSURANCE CORP.

request and authorization for bank payment plan

It's the simplest method of paying your premium. No more checks to write! It's automatic and reliable. We call it electronic funds transfer (EFT for short). It allows for peace of mind however you do business — whether it's online or through the mail.

Online: Groups that receive invoices online, you have the freedom to choose when we debit your account. When you're ready, just visit our website, ameritasgroup.com, sign into your secure account and click PAY BILL. We'll draft your premium payment right away.

Mail: Groups that receive their invoices through the mail, just authorize us to debit your account each month and we'll do the rest. It's the forget-proof method of paying your premium.

authorized agreement for prearranged payments (debits)

Group Policy #_____ Phone #_____

Policyholder Name _____

Policyholder Contact _____

☐ New Authorization ☐ Change of Account
☐ Checking Account ☐ Savings Account

I hereby authorize Ameritas to initiate debit entries to the account number listed below, and at the bank named below, herein called BANK, to debit the same to such account. The EFT draft will be monthly or quarterly, whichever payment option was selected, on or about the first day of the coverage period.

Bank Account Number _____ Bank Routing Number (9 digits) _____

Bank Name _____

Account Name _____

Address _____

City _____ State _____ ZIP _____

Phone Number of Financial Institution _____

To ensure a timely and effective setup, it is necessary to send a voided check with this request.

This authorization is to remain in full force and in effect until BANK has received written notification of its termination in such time and such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first.

Name (Print) _____ Title of Authorized Signer _____

Signature _____

Date _____ Federal Tax ID# _____

Please keep a copy of this form for your records.

addendum Spirit Group Employer Dental and/or Vision Insurance

Effective Date Requested _____, ☐ 1st or ☐ 15th, _____ (Month / Day / Year)	☐ 2-4 Employees ☐ 5-9 Employees ☐ 10-199 Employees	☐ Paper Billing Statement

SPIRIT DENTAL *(not available in WA; NY must have a minimum of 5 employees enrolling in the plan or 50% participation)*

*For all states Except: GA, LA, MS, MT, RI, TX, **WA** and PA restricted counties **of Forest & Potter***

Select ONE:	☐ High Plan ☐ Low Plan	*Select ONE*: ☐ Voluntary *OR* ☐ Employer Funded
For states of: GA, LA, MS, TX		
Select ONE:	☐ High Passive PPO Plan ☐ Low Passive PPO Plan	*Select ONE*: ☐ Voluntary *OR* ☐ Employer Funded
For states of: MT and RI and for PA counties of Forest & Potter		
Select ONE:	☐ High Plan (Indemnity) ☐ Low Plan (Indemnity)	*Select ONE*: ☐ Voluntary *OR* ☐ Employer Funded

Plan options (Select all that apply and adjust premium accordingly)

☐ Employer Voluntary (premium x 1.05)
☐ 100% Family-related (premium x 1.15)

☐ Endodontics/Periodontics-Basic (premium x 1.08)
☐ Teeth Bleaching (premium x 1.03)
☐ Orthodontia – Adult & Child *(Adult & Child available with the High plan, Child only with the Low plan) (see brochure for rates). Ortho coverage not available in CT, IL, NJ or NY. Ortho not available in group size 2-4.*

☐ Increase Calendar Year Max to $1500 (premium x 1.14)
☐ Increase Calendar Year Max to $2000 (premium x 1.20)
☐ Increase Calendar Year Max to $3000 (premium x 1.36)*
☐ Increase Calendar Year Max to $5000 (premium x 1.56)*
** not available for group size 2-4*

☐ $50/$150 Calendar Year Deductible – in lieu of Lifetime Deductible (premium x 1.03)
☐ $25/$75 Calendar Year Deductible – in lieu of Lifetime Deductible (premium x 1.08)
☐ $0/$0 Calendar Year Deductible – in lieu of Lifetime Deductible (premium x 1.15) $100
☐ Lifetime Deductible - in lieu of $50/$150 Annual Deductible (Low Plan) (premium x 1.03)
☐ Increase from 80th to 90th Percentile of Usual & Customary (premium x 1.04) (only for states of AK, GA, LA, MS, MT, NJ, PA (restricted counties of Forest & Potter) and RI).
☐ 80th Percentile of Usual & Customary (premium x 1.20)
☐ 90th Percentile of Usual & Customary (premium x 1.25)

☐ Dental Rewards – available only on $1000, $1500 and $2000 Calendar Year Maximum plans (premium x 1.02)

☐ Group is a Restricted Industry* (premium x 1.15) *(applies to group size 25 or greater)*
☐ Selecting both Dental and Vision (EyeMed or VSP) (vision premium x .95)
☐ For groups without prior coverage (required base premium x 1.15)
** There will be a 12 month waiting period for major services for groups that do not choose to add the 15% increase to the base rates. 15% buy up is required in the states of ME, NM & VT.*

Dental Premium	Employee Only $ _____ Employee + One $ _____ Employee + Family $ _____
There are initially _____full-time employees of which _____will be enrolled in this plan.	

Selecting a vision plan along with your dental? Please complete vision section below

SPIRIT VSP VISION – CHOICE PLUS AFFILIATES PLAN *(not available in MA, MD, MT, RI or WA)*

Select ONE: ☐ Voluntary *OR* ☐ Employer Funded

Select ONE:	☐ Plan 1 (V24653) ☐ Plan 2 (V24654) ☐ Plan 3 (V24655) ☐ Plan 4 (V24656) ☐ Plan 5 (V24657) ☐ Plan 6 (V24658) ☐ Plan 7 (V24659) ☐ Plan 8 (V24660)	100% Family-related (premium x 1.15) *(Select if applicable and adjust premium accordingly)*
VSP Vision Premium	Employee Only $ _____ Employee + One $ _____ Employee + Family $ _____	
There are initially _____full-time employees of which _____will be enrolled in this plan.		

*Restricted industries: Financial, Investment, Insurance, or Real Estate Services. Medical Offices and Hospitals. Legal, Accounting, Engineering, Architectural, or Scientific Services. Membership or Charitable Organization Offices, other Professional Services. Schools or Educational Services.

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

Spirit Group Dental and Vision Insurance Employee Enrollment Form

1. EMPLOYER SECTION *(to be completed by employer)*

Policy and Div. # 010-	Cert. #	COBRA (If individual is a continue): Qualifying Event	Date of Event
Employer Name and Address		Full-Time Hire Date	If Rehire, Rehire Date
Occupation		Hours Worked Each Week	

2. EMPLOYEE SECTION *(to be completed by employee)*

Last Name	First Name	Middle Initial
Address		
City	State	Zip

Phone #	Date of Birth	☐ Male ☐ Female	Marital Status ☐ Married ☐ Single	Social Security Number *(Required)*

E-mail address *(limit of 60 characters)*

COVERAGE ELECTION

☐ Dental Only (choose Classic Network ☐ OR Value Network ☐)
☐ Vision Only ☐ Dental & Vision ☐ Waive Coverage *(complete Section 5 below)* ☐ Terminate All Coverage

3. DEPENDENTS (list all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Last Name, First Name, MI	Dental add / drop	Vision Add / drop	Relationship	Gender	Date of Birth	Social Security # *(Not Required)*
	☐ ☐	☐ ☐		☐M ☐F		
	☐ ☐	☐ ☐		☐M ☐F		
	☐ ☐	☐ ☐		☐M ☐F		
	☐ ☐	☐ ☐		☐M ☐F		
	☐ ☐	☐ ☐		☐M ☐F		

Are you covered under another DENTAL plan? ☐Yes ☐No | Are your dependents covered under another DENTAL plan? ☐ Yes ☐ No

Are you covered under another VISION plan? ☐Yes ☐No | Are your dependents covered under another VISION plan? ☐Yes ☐No

This policy 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.

_____ _____

Employee 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.)

4. To CHANGE Coverage (check as appropriate below and complete above sections with necessary information)

☐ Name change | New Name | Old Name

☐ Add Dependent Coverage: ☐ Due to Marriage; date of Marriage _____ ☐ Due to Birth or Adoption; date of event _____
☐ Due to loss of coverage, date of loss and reason _____ ☐ Other, Date of event and reason_____

☐ Drop Dependent Coverage: # of Dependents still covered _____Effective date of drop _____
Reason: ☐ Divorce ☐ Death ☐ Annual Election Period ☐ Exceeds maximum age to quality as dependent

5. To WAIVE Coverage 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 ☐ spouse/domestic partner ☐ child(ren) only ☐ spouse/domestic partner and child(ren)
Because_____Name of insurance company and employer of dependent_____

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.

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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. 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.