

# 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	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> 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)
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> 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)

<input type="checkbox"/> Name change	New Name _____	Old Name _____
<input type="checkbox"/> Add Dependent Coverage:	<input type="checkbox"/> Due to Marriage; date of Marriage _____	<input type="checkbox"/> Due to Birth or Adoption; date of event _____
	<input type="checkbox"/> Due to loss of coverage, date of loss and reason _____	<input type="checkbox"/> Other, Date of event and reason _____
<input type="checkbox"/> Drop Dependent Coverage:	# of Dependents still covered _____	Effective date of drop _____
Reason:	<input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Annual Election Period <input type="checkbox"/> 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.

**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. 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.