application Individual Insurance Form

Ameritas Life Insurance Corp. 5900 O Street / P.O. Box 81889 / Lincoln, NE 68501-1889

Ameritas

☐ **Dental** ☐ **Dental with Eye Care** ☐ **Dental with Eye Care Exam** ☐ **Stand Alone Eye Care**

☐ **Dental with Hearing & Lasik** ☐ **Dental with Eye Care, Hearing & Lasik**

Plan Selected: _____

Policyholder Information

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner* ☐ Civil Union* *As defined by state law.			Social Security Number	Affiliation, if applicable
Policyholder's Last Name		First Name		MI
Date of Birth	☐ Male ☐ Female	Phone Number	E-Mail Address (limit of 60 characters)	
Street Address		Apt. #	City	State / ZIP
Billing Street Address (if different than above)		Apt. #	City	State / ZIP

Have you been covered under another dental policy within the last 30 days? ☐ Yes ☐ No

If yes: 1. Please provide an Evidence of Coverage letter, with dates of coverage, from your prior carrier if you are eligible for takeover benefits.
2. Please complete the attached Replacement form.

Applicants and Dependents cannot have the same type of coverage under another Ameritas plan.
(i.e. no two Ameritas dental plans, no two Ameritas eye care plans).

Dependent Coverage Information

List all eligible dependents to be covered. (Policyholder must be enrolled to cover dependents)

Print Full Legal Name (last, first, MI)	Relationship	Sex	Date of Birth	Social Security No.
1				
2				
3				
4				
5				

Premium payment frequency: . . ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

Premium method: . . . . . ☐ EFT ☐ ACH ☐ Credit Card ☐ Check ☐ Direct Bill

Agreements by Ameritas

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.

Any policy including riders and rate notifications 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., insurance 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.

THIS POLICY DOES NOT INCLUDE COVERAGE OF PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE AFFORDABLE CARE ACT. COVERAGE OF PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE IN THE STATE OF COLORADO AND CAN BE PURCHASED AS A STAND-ALONE PLAN. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR CONNECT FOR HEALTH COLORADO TO PURCHASE EITHER A PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE OR AN EXCHANGE-QUALIFIED STAND-ALONE DENTAL PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE.

THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Agreements by Policyholder

I hereby apply for insurance, for which I am eligible. I agree to be responsible for my premiums and those of my enrolled dependents. I acknowledge receipt of the outline of coverage. I understand coverage is NOT in force until the Company issues a Policy showing a Policy Effective Date.

☐ I consent to receiving my Policy, Explanation of Benefits, and other plan information electronically and I will electronically affirm my consent to do so. I understand I need Internet access and that I can withdraw my consent at any time per the notification instructions below. I understand I can receive any of the documents in paper form if I choose.

I have read the statements and answers to the above questions and they are complete and true to the best of my knowledge and belief. All statements are deemed to be representations and not warranties. I understand that it is my responsibility to give notice to Ameritas of changes in my e-mail address or any information above, as well as my status and my family's status that affect coverage, such as marriage, births, or death of someone covered under the policy. I will provide notice electronically through e-mail or in writing to Ameritas or its designee:

Ameritas Life Insurance Corp., PO Box 81889, Lincoln, NE 68501-1889 / 800-487-5533 / e-mail: group@ameritas.com

I understand the policy I am applying for provides dental/eye care/hearing and Lasik benefits only and is not a Medicare supplement.

X _____ _____

Policyholder Signature (do not print) Date

_____ _____

Insurance Producer Name and/or Number (if applicable) Date

regulatory notes

Review your policy carefully

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.