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 or eye care 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.

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

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 below.)

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.