



Enrollment Form For Dental Insurance Program

Insured by Ameritas Life Insurance Corp.

Enrollment Form From: Ameritas Life Insurance Corp. 475 FALLBROOK BLVD. ¥ LINCOLN, NE 68521	
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(Answer ALL questions completely.)

NEW HIRE <input type="checkbox"/> DATE OF HIRE _____	CURRENT MEMBER OF AVMA <input type="checkbox"/> AVMA MEMBERSHIP NUMBER _____	CURRENT EMPLOYEE OF AN AVMA MEMBER <input type="checkbox"/> (required for all applicants)
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SECTION 1: APPLICANT INFORMATION

NAME OF PRIMARY APPLICANT (Last, First, MI)			
SOCIAL SECURITY NUMBER	DATE OF BIRTH	<input type="checkbox"/> MALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED
		<input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED
PRIMARY APPLICANT S ADDRESS (P.O. Boxes are not accepted)			
CITY	STATE	ZIP CODE	
PHONE NUMBER (Work)	PHONE NUMBER (Home)	E-MAIL ADDRESS	
Is your employer contributing to your premium? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If yes, EMPLOYER NAME AND BILLING ADDRESS			
CITY	STATE	ZIP CODE	

SECTION 2: DENTAL PLANS

DO YOU WORK AT LEAST 20 HRS PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU COVERED FOR DENTAL INSURANCE UNDER ANOTHER PLAN? APPLICANT <input type="checkbox"/> YES <input type="checkbox"/> NO DEPENDENT <input type="checkbox"/> YES <input type="checkbox"/> NO
REQUESTED EFFECTIVE DATE ____ / ____ / _____	
COVERAGE (Applied for): <input type="checkbox"/> APPLICANT ONLY <input type="checkbox"/> APPLICANT PLUS ONE DEPENDENT <input type="checkbox"/> SPOUSE OR <input type="checkbox"/> CHILD <input type="checkbox"/> APPLICANT PLUS TWO OR MORE DEPENDENTS <input type="checkbox"/> SPOUSE AND/OR <input type="checkbox"/> CHILDREN	
DENTAL PLAN (Choose one of the three plans) <input type="checkbox"/> STANDARD PLAN <input type="checkbox"/> CLASSIC PLAN <input type="checkbox"/> PREMIER PLAN	

SECTION 3: BILLING INFORMATION

Payment Method

MONTHLY EZ PAY — — ONE MONTH PREMIUM REQUIRED (No administration fee) Complete Section 4

MONTHLY BILLING OPTION — — ONE MONTH PREMIUM REQUIRED (\$3 per person up to \$15 maximum administration fee)

QUARTERLY BILLING OPTION — — THREE MONTHS PREMIUM REQUIRED (\$8 quarterly administration fee)

SEMI-ANNUAL BILLING OPTION — — SIX MONTHS PREMIUM REQUIRED (\$8 semi-annual administration fee)

total Payment Including Administration fee With Application required
 Make Check Payable to Ameritas Life Insurance Corp.

SECTION 4: EZ PAY AGREEMENT (Complete only if you selected monthly EZ pay option)

EZ PAY AGREEMENT(Only available if employer is NOT contributing premium)

PAYOR NAME OR DEPOSITOR IF DIFFERENT		RELATIONSHIP TO Applicant
NAME OF FINANCIAL INSTITUTION		CHECKING/SAVINGS ACCOUNT NUMBER
ADDRESS		
CITY	STATE	ZIP CODE
SPECIFY TYPE OF ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS signature: X _____ DATE: / /		

ABA 9 DIGIT ROUTING NUMBER (SEE BELOW OR PLEASE CALL YOUR FINANCIAL INSTITUTION FOR ASSISTANCE)

Ameritas and/or HealthPlan Services, acting as Plan Administrator on behalf of Ameritas, is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month, until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Certificate is not issued.

I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by HealthPlan Services, and I agree that the bank named shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Ameritas and/or HealthPlan Services in writing.

ATTACH YOUR initial CHECK OR MONEY ORDER for premium payment		1117
Joe Smith 123 Main Street Anytown, IL 12345		
Pay to the order of <u>AMERITAS</u>		Date _____
		\$ _____ Dollars
For _____		
Routing Number <u>123456789</u> 1234567891011 1117		

EZ Pay PLAN APPLICANTS ONLY
Voided Check
(Deposit Slips are not acceptable)

SECTION 5: CONTRACT

PLEASE SIGN AND 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.

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.

As a member/employee, I hereby apply for insurance. These benefits were 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.

Please note master policy providing dental insurance coverage for which you are applying is controlled by the laws of the state of Florida

Applicant's Signature X _____ (required) State where application signed _____

Soliciting Producer: Printed Name: _____ Signature: _____
State where application signed by producer: _____ Date: _____

**Once completed, signed and dated, mail this form along with your premium payment to:
AVMA GHLIT, P.O. Box 30475, Tampa, FL 33630-3475, Phone: 1-800-621-6360**