Enrollment Form For Dental Insurance Program

Insured by Ameritas Life Insurance Corp.
Administered by HealthPlan Services

Enrollment Form From:
Ameritas Life Insurance Corp.
c/o ASA/HPS
P.O. Box 30474, Tampa, FL 33630-3474

Is this application for: ❑ New Business (first time applicant)

❑ Change to existing policy
Current policy number ___________________________

(Answer ALL questions completely).

CURRENT **MEMBER** OF ASA ❑
MEMBERSHIP NUMBER ____ (required for all applicants)

SECTION 1: APPLICANT INFORMATION

NAME OF PRIMARY APPLICANT (Last, First, MI)

SOCIAL SECURITY NUMBER | DATE OF BIRTH | ❑ MALE | ❑ FEMALE | ❑ MARRIED | ❑ DIVORCED | ❑ SINGLE | ❑ WIDOWED

PRIMARY APPLICANT'S ADDRESS (P.O. Boxes are not accepted)

CITY | STATE | ZIP CODE

PHONE NUMBER (Work) | PHONE NUMBER (Home) | E-MAIL ADDRESS

SECTION 2: DENTAL PLANS

ARE YOU COVERED FOR DENTAL INSURANCE UNDER ANOTHER PLAN?

APPLICANT ❑ YES ❑ NO **DEPENDENT** ❑ YES ❑ NO

REQUESTED EFFECTIVE DATE _______ /_______ /_______________

SELECT PLAN (Choose 1 of the 3 plans) ❑ PLAN 1 ❑ PLAN 2 ❑ PLAN 3

COVERAGE (Applied for)

❑ APPLICANT ONLY

❑ APPLICANT PLUS ONE DEPENDENT ❑ SPOUSE OR ❑ CHILD

❑ APPLICANT PLUS TWO OR MORE DEPENDENTS ❑ SPOUSE AND/OR ❑ CHILDREN

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 (plus $3 monthly administration fee)
❑ QUARTERLY BILLING OPTION — THREE MONTHS PREMIUM REQUIRED (plus $3 quarterly administration fee)
❑ SEMI-ANNUAL BILLING OPTION — SIX MONTHS PREMIUM REQUIRED (plus $3 semi-annual administration fee)
❑ ANNUAL BILLING OPTION — TWELVE MONTHS PREMIUM REQUIRED (plus $3 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

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

❑ CHECKING ❑ SAVINGS **SIGNATURE: X**____________________ DATE: / /

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

Ameritas Life Insurance Corp. ("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. 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 Ameritas and/or 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 HealthPlan Services in writing.

ATTACH YOUR INITIAL CHECK OR MONEY ORDER FOR PREMIUM PAYMENT

Joe Smith
123 Main Street
Anytown, IL 12345

1117

Date

Pay to the order of AMERITAS LIFE INSURANCE CORP. $

Dollars

For

Routing Number

123456789 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. ■ 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. ■ 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 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 Kansas, Nebraska, Oregon 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 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: The master insurance policy providing coverage is governed by the laws of Georgia.

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.

ASA Member Signature X____________________ Date__________
(required)

Agent Name____________________ FL License #__________

Once completed, signed and dated, mail this form along with your premium payment to:

ASA/HPS, P.O. Box 30474, Tampa, FL 33630-3474, Phone: 1-877-473-6031