Group Enrollment / Change or Waiver Form

COBRA - If the individual is a continuee:
Qualifying Event_____ Date of Event _____

AMERITAS LIFE INSURANCE CORP.
MAILING ADDRESS:
P.O. BOX 81889, LINCOLN, NE 68501-1889
800-659-2223 / FAX: 402-466-0003

POLICY AND DIV. # 010- _____ CERT.# _____

NAME AND ADDRESS OF EMPLOYER (Policyholder) _____

1. TO ENROLL ☐ DENTAL ☐ EYE CARE ☐ TO TERMINATE ALL COVERAGES

EMPLOYEE INFORMATION: MARITAL STATUS ☐ SINGLE ☐ MARRIED

SOCIAL SECURITY NUMBER _____ DEPT.# _____

EMPLOYEE'S LAST NAME, FIRST, MI _____

DATE OF BIRTH _____ ☐ MALE ☐ FEMALE

FULL TIME DATE OF HIRE _____ ☐ REHIRE - REHIRE DATE _____

OCCUPATION _____

HOURS WORKED EACH WEEK _____ ARE YOUR EARNINGS PAID: ☐ HOURLY OR ☐ SALARIED

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

ARE YOU COVERED UNDER ANOTHER DENTAL INSURANCE PLAN? **EMPLOYEE: ☐ YES ☐ NO** **DEPENDENTS: ☐ YES ☐ NO**

ARE YOU COVERED UNDER ANOTHER EYE CARE INSURANCE PLAN? **EMPLOYEE: ☐ YES ☐ NO** **DEPENDENTS: ☐ YES ☐ NO**

DEPENDENT COVERAGE INFORMATION. LIST ALL ELIGIBLE DEPENDENTS TO BE ADDED OR DELETED. (Employee must be enrolled to cover dependents)

PRINT FULL LEGAL NAME (LAST, FIRST, M)	ADD	DROP	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
1						
2						
3						
4						
5						
6						
7						

PLEASE SIGN (EMPLOYEE / POLICYHOLDER SIGNATURES)

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. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ X _____

Employee Signature (Do Not Print) *Date* *Policyholder Signature* *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.)

EMPLOYEE LATE ENTRANT DATE _____

DEPENDENT LATE ENTRANT DATE _____

Effective Date	Class	Dep. Code

2. TO CHANGE

☐ **NAME CHANGE**

NEW NAME _____ OLD NAME _____

☐ **ADD DEPENDENT COVERAGE**

☐ IF DUE TO MARRIAGE, WHAT IS THE **DATE OF MARRIAGE?** _____

☐ IF DUE TO BIRTH/ADOPTION OF A CHILD, WHAT IS THE **DATE OF EVENT?** _____

☐ IF DUE TO LOSS OF COVERAGE, **DATE** AND **REASON:** _____

☐ OTHER, THE **DATE OF EVENT** AND PLEASE **EXPLAIN:** _____

☐ **DROP DEPENDENT COVERAGE** NUMBER OF DEPENDENTS STILL COVERED: _____

☐ DUE TO DIVORCE ☐ DUE TO DEATH ☐ DUE TO ANNUAL ELECTION PERIOD

☐ OTHER: PLEASE EXPLAIN: _____

EFFECTIVE DATE OF DROP: _____

3. TO WAIVE

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** (does not apply to TRUST policies) ☐ **spouse only** ☐ **child(ren) only** ☐ **spouse and child(ren)**

because_____ Name of Insurance Co. & Employer of Dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.