

enrollment/change/waiver Group Insurance Form

Ameritas Life Insurance Corp. of New York 1350 Broadway, Suite 2201 / New York, NY 10018 / 1-800-628-8889



Policy and Div. # **026-** _____
Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event
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Name and Address of Employer (Policyholder) _____

1 to enroll Dental Eye Care To terminate all coverages Select plan High Middle Low

Employee Information

Marital Status Single Married Civil Union* Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, 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 _____

E-mail address (limit of 60 characters) _____

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, MI)	Dental		Eye Care		Relationship	Sex	Date of birth	Social Security no.	College student?
	add	drop	add	drop					
1 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
2 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
3 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
4 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
5 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>

Please Sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**
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 to the best of my knowledge. 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 (do not print) Date

Any person who knowingly and with intent to defraud any insurance company or other reason 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 shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.

Employee late entrant date _____	Effective Date	Class	Dep. Code
Dependent late entrant date _____			

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, what is the date of event? _____
 If due to loss of coverage, date and reason: _____
 If other, the date of event and please explain: _____

Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop: _____
 Due to divorce Due to death Due to annual election period Exceeds maximum age to qualify as dependent
 Other (please explain) _____

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/domestic partner child(ren) only spouse/domestic partner and child(ren)
because _____

Name of insurance company and 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.