INDIVIDUAL DENTAL
Applicant Preparation Sheet

HealthPlan Services
Gain the advantage.

AMERITAS GROUP
We're Ameritas. We're for people.®
A Division of Ameritas Life Insurance Corp.
A UNIFI Company

Dear Valued Agent:
In order to help ensure the application process goes smoothly, we strongly encourage you to provide the following information with the insurance application.

1. _____
Name of Writing Agent (if applicable) Agent's Business Telephone Number

2. _____
Name of General Agent (GA) (if applicable) GA's Business Telephone Number

3. _____
Requested Plan Name Requested Annual Maximum

Eye Care ❑ Yes ❑ No Requested Effective Date _____

4. Requested Premium Payment Frequency ❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual
Requested Premium Payment Method ❑ EZ Pay (EFT) ❑ Direct Bill/Check (not available in Kentucky, Michigan and Tennessee)
If direct bill, an $8 billing fee per payment frequency applies.

5. If requesting EZ Pay, complete the EZ Pay Agreement.

PAYOR NAME OR DEPOSITOR IF DIFFERENT | RELATIONSHIP TO APPLICANT | X PRIMARY PAYOR SIGNATURE | DATE

NAME OF FINANCIAL INSTITUTION | CHECKING / SAVINGS ACCOUNT NUMBER

FINANCIAL INSTITUTION ADDRESS | CITY | STATE | ZIP

SPECIFY TYPE OF ACCOUNT ❑ CHECKING ❑ SAVINGS

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.

Joe Smith
123 Main Street
Anytown, IL 12345

ATTACH YOUR INITIAL CHECK OR MONEY ORDER FOR PREMIUM PAYMENT

Date _____

Pay to the order of **HEALTHPLAN SERVICES** $ _____

Dollars

For _____

ROUTING NUMBER
123456789 1234567891011 1117

EZ PAY PLAN APPLICANTS ONLY

VOIDED CHECK

DEPOSIT SLIPS ARE NOT ACCEPTABLE

6. Mail completed insurance application, applicant preparation sheet and first month's premium to:

HealthPlan Services
P.O. Box 30474
Tampa, FL 33630-3474

application

individual insurance form

AMERITAS LIFE INSURANCE CORP.
5900 O Street / P.O. Box 81889
Lincoln, NE 68501-1889

☐ **Dental** ☐ **Dental with Eye Care Policy**

Plan selected_____

policyholder information

Marital Status ☐ Single ☐ Married ☐ Domestic Partner (if applicable)

Social Security number _____ Affiliation, if applicable_____

Policyholder's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Phone number_____

Street address_____ Apt. #_____ City_____ State_____ ZIP_____

Billing address, if different from above_____ Apt. #_____ City_____ State_____ ZIP_____

E-mail address (limit of 60 characters) _____

Have you been covered under another dental 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 number
1				
2				
3				
4				
5				

Premium payment frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

Premium method: . . . . . ☐ EFT ☐ Check

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:

HealthPlan Services, P.O. Box 30474, Tampa, FL 33633-1425 / 800-237-1276

I understand the policy I am applying for provides dental or dental and eye care benefits only and is not a Medicare supplement.

X _____
Policyholder Signature **Date**

X _____
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 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 policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que fi gura en su tarjeta de identifi cación o al 877-233-2797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

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 D.C. 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.

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 Georgia, Kansas, Nebraska, Oregon, Vermont 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 Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Note for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 New Mexico and Rhode Island 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 civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note for Texas Residents: 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, may be 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.

A Division of Ameritas Life Insurance Corp.
A UNIFI Company
475 Fallbrook Blvd. / Lincoln, NE 68521-9033
(402) 467-1122 / (800) 745-1112 / Facsimile: (402) 309-2573

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Ameritas Life Insurance Corp. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

a. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

c. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. Failure to complete this accurately may provide a basis for the company to deny any future claims and to refund your premium as stated in the coverage of your Policy. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____ _____

(Date) (Applicant's Signature)