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



Name and Address of Employer (Policyholder) To enroll Dental Eye Care To terminate all coverages	Policy and Div. # 026-	••					A: If individual	Qualifying Event			[1	Date of Event		
To enroll Dental Eye Care To terminate all coverages			L	is a continuee:										
Employee Information	Name and Address of Employer (Policyholder)						,							
Marries Istatus Single Married Civil Union* Dept. number	to enroll □ Dental □ Eye Care		ter	m	ina	te	all coverage	8						
Dept. number Dept	Employee Information													
Employee's last name, first name, MI Maile Female Full time date of hire Rehire: Rehire date Decupation Hours worked each week Are your earnings paid: Hourly or Salaried Street address Stree	Marital Status Single Married Civil Union	ו* 🗌	Don	nes'	tic I	art	ner* *As defined	by state la	w or ye	our Group.				
Date of birth Male Female Full time date of hire Rehire: Rehire date	Social Security number	····	_ D	ept	. nı	drnu	er							
Hours worked each week	Employee's last name, first name, MI													
Strote address (limit of 60 characters) Are you covered under another dental insurance plan? Employee: Yas No Dependents: Yes No No No No No No No N	Date of birth	emale	F	ull	tim	e da	ate of hire			_ Rehire: R	tehire date		***************************************	
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Employee: Yes No Dependents: Yes No No Yes No	Street address						City				State	ZIP		
Are you covered under another dental insurance plan?														
Print full legal name (last, first. MI) Dental Eye Care Add drop add	Are you covered under another eye care insurance	plan?						Employ	ee:	☐ Yes ☐ No	Depen	dents: 🗌 Ye		
Print full legal name (last, first. MI) add drop add drop Relationship Sex Date of birth Social Security no. Student?	Dependent Coverage Information List all eligib							d. (Emplo	yee n	nust be enrolled t	o cover der	endents)		
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. It contributions are required, lauthorize my employer to deduct premiums from my salary. This FOLLOWING APPLIES ONLY TO SECTION 125 HEXIBLE BENEFIS 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 have read and understant. I represent that the information in lave provided is complete and accurate to 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 Employee signature (do not print) Date Policyholder Signature (do not print) Dat	Print full legal name (last first MI)							shin	Sev	Nate of hirth	Socia	l Security no		
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tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- Policy Name and Group Number to make sure plan members are added to the correct group.
- Department/Division Numbers so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- Social Security Numbers the most important identifier for plan members when calling in with claims or administrative questions.
 Please double check to make sure your social security number is accurate and written clearly.
- Full-time Employment Date needed so the correct effective date is calculated for new members.
- Class Number needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes — When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

- 1) submit clear, legible enrollment forms.
- 2) underline or circle important information.
- 3) use blue or black ink.

Don't:

- 1) submit dark copies as they appear black on imaging.
- 2) highlight, which blackens the area so it cannot be read.
- 3) write on the top or bottom margins. This information is not always captured on the image system.