Ameritas Dental Plan – Enrollment Form

Ameritas fulfilling life

Employee Name (Last, First, MI)	**Employee Number**

Please check one of the following:

☐ I AM **ENROLLING** MYSELF AND/OR MY DEPENDENTS IN THE AMERITAS DENTAL PLAN (**CONTINUE TO FILL OUT FORM)**

☐ I AM **WAIVING ENROLLMENT** FOR MY MYSELF/DEPENDENTS IN THE AMERITAS DENTAL PLAN OR **I DO NOT WISH TO ENROLL** AT THIS TIME. I MAY VOID THIS ELECTION FORM & CHOOSE TO ENROLL BY COMPLETING A NEW ENROLLMENT FORM WITHIN 60 DAYS OF MY HIRE DATE. (No other info needed) (**STOP HERE AND SIGN ON LINE BELOW**):

I DECLINE DENTAL COVERAGE: **SIGN** _____ **DATE**: _____

Address: Street	**City**	**State**	**Zip Code**	**Phone Number** ( ) -

Emp. Date of Birth Mo Day Year	**Date of Hire** Mo Day Year	**Marital Status** ☐ Married ☐ Single	**Sex** ☐ Male ☐ Female	**SSN**

Type of Enrollee: ☐ New Hire Enrollment ☐ Special Enrollee Reason: _____ Insurance Start Date:_____ ☐ Open Enrollment

DEPENDENTS TO BE ENROLLED

Spouse Name (Last, First, MI)	**Spouse SSN**	**Spouse Date of Birth**	**Spouse Sex** ☐ Female ☐ Male

Date of Marriage: _____

Dependent Child #1 Name (Last, First, MI)	**Child SSN**	**Child Date of Birth**	**Child Sex** ☐ Female ☐ Male
Dependent Child #2 Name (Last, First, MI)	**Child SSN**	**Child Date of Birth**	**Child Sex** ☐ Female ☐ Male
Dependent Child #3 Name (Last, First, MI)	**Child SSN**	**Child Date of Birth**	**Child Sex** ☐ Female ☐ Male
Dependent Child #4 Name (Last, First, MI)	**Child SSN**	**Child Date of Birth**	**Child Sex** ☐ Female ☐ Male

Are any dependent children adopted?	Yes	No	If yes, indicate name and date of placement
Have you included stepchildren?	Yes	No	If yes, indicate names
Are any dependent children adopted?	Yes	No	If yes, indicate name and date of placement
Are the stepchildren dependent on you for support and maintenance?	Yes	No	

Choose Dental Plan :	**High Plan**		**Low Plan**	
☐ Employee	☐ Employee & Child(ren)		☐ Employee	☐ Employee & Child(ren)
☐ Employee & Spouse	☐ Employee, Spouse, & Child(ren)		☐ Employee & Spouse	☐ Employee, Spouse, & Child(ren)

☐ I hereby apply for the group benefit(s) indicated above.

☐ I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined by the group plan) of full time service.

☐ I authorize my employer to take deductions from my pay to cover the cost of my dental policy

☐ The information provided above is true and correct to the best of my knowledge.

☐ Any person with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

☐ I understand that I am allowed to use flexible pay for the purpose of qualified benefits as part of a flexible benefits plan under Section 125 of the Internal Revenue Code. I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for the dental coverage shown above. Such reductions, considered as elective contributions under the plan, shall commence with my first paycheck following the effective enrollment date. I further authorize future adjustments in the amount of the salary reduction in the event that the cost of coverage is changed during the plan year. I also understand that the purpose of this program is to allow employees to select this qualified benefit within the guidelines of the Internal Revenue Code. **I also understand that this election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are in conjunction with a qualifying event, e.g.; marriage, divorce, death of a spouse or child, birth or adoption of a child and termination of employment of a spouse**

SIGNATURE OF EMPLOYEE _____ **DATE SIGNED** _____