Return Core Dental apps to:
Kristin@nibconline.com
Or Fax to: 501-372-2221

application
individual insurance form

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

☐ **Dental with Eye Care Hearing & Lasik** **Plan Selected** _____

policyholder information Marital Status: ☐ Single ☐ Married ☐ Domestic Partner (if applicable) ☐ Civil Union (if allowed by state law)

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

Premium payment frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual Premium method: . . . . . ☐ EFT ☐ Credit Card

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 anytime 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:

SASid / P.O. Box 1086, Janesville, WI 53547 / 800-279-2290

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

X _____
Policyholder Signature **Date**

X _____
Insurance Producer Name and/or Number (if applicable) **Date**

Eligiblity Information

Have you previously had group dental coverage within the last 30 days?

( ) Yes ( ) No

We may be able to waive your waiting (elimination) period (the period of time you must be insured by the plan before being eligible to receive certain benefits) if you qualify for takeover benefits.

To qualify, you must have had dental coverage within the last 30 days from the date this application is completed and signed. The benefits under the prior plan must be similar to the benefits you're applying for. Also, you will be asked to sign a Replacement Notice.

Coverage under the prior plan must terminate prior to the effective date under this plan in order for Takeover to be granted.

This information is needed to verify you are eligible for takeover benefits. Some of the requested information should be on the insurance identification card or policy documents obtained at the time your previous coverage began.

* = Required Field

* Primary Member First Name		
* Primary Member Last Name		
* Policy Number		
* Insurance Carrier Name		
* Insurance Carrier Phone Number		(XXX-XXX-XXXX)
* Effective Date of Coverage		(MM/DD/YYYY)
* Termination Date		(MM/DD/YYYY)

Please note: if you are currently insured on an Ameritas dental plan, your coverage on that plan must terminate on or before the effective date of your coverage under the new individual dental plan.

If you are unable to provide the information requested above you will be issued a policy without takeover benefits. You may still

qualify for takeover benefits by providing an evidence of coverage letter from your prior carrier. You must provide this evidence of coverage letter within 30 days to:

InsuranceTPA.com
P.O. Box 998
Janesville, WI 53547

We will then review your application for a policy with takeover benefits.

Payment Information

Payment Type:
- ○ Electronic Funds Transfer (Checking Account)
- ○ Credit or Debit Card

Account Type ○ Checking Account

Name on Account

Bank Name

Bank Routing Number (9 digit number)

Bank Account Number

Billing Address

Billing Address 2 (Apt. No., Suite No., etc.)

Billing City

Billing State

Billing Zip

Type of Card ○ Visa ○ Mastercard

Name on Card

Card Number - - -

Expiration Date /

Billing Address

Billing Address 2 (Apt. No., Suite No., etc.)

Billing City

Billing State

Billing Zip

E-Signature for Core Dental Insurance

agreements by Ameritas

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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

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InsuranceTPA.com / P.O. Box 998, Janesville, WI 53547 / 800-279-2290

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

By signing below, I AUTHORIZE InsuranceTPA.com TO COLLECT ANY AND ALL PREMIUMS DUE FOR THIS COVERAGE.

For Core Dental Insurance policies, InsuranceTPA.com requires that after a free look-back period, policyholders make a commitment through the initial 12 monthly periods. Once they receive a policy, policyholders have a 10 day "look-back period" in which they can cancel their plan; the application fee is non-refundable. The 12 month commitment is intended to keep the rates for the Core Dental plans attractive for current and future subscribers.

E-Signature: ○ I Agree ○ I Decline