GemStar℠ Flex Vision

Coverage to fit your needs.

GemStar Flex Vision comes with the freedom to use any vision provider, but offers greater savings through additional network discounts.

- For employer groups with 2-99 lives
- Employee option of VSP®, EyeMed or non-network plan
- No waiting periods with a two-year rate guarantee

Ameritas
fulfilling life.

GR 6948 12-16

Plan Details

Plan Option	VSP®		EyeMed		Non-Network
Annual	$10 exam / $25 material		$10 exam / $25 material		NA
Deductible Frequencies	Exams and lenses once a year Frames once every two years		Exams and lenses once a year Frames once every two years		NA
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Eye Exam	100% Covered	Up to $45	100% Covered	Up to $35	Flat annual maximum of $150 is reimbursed for exams, lenses and frames collectively
Frames	Up to $130	Up to $70	Up to $100	Up to $45	
Contacts	Up to $130	Up to $105	Up to $115	Up to $100	
Single Lenses	100% Covered	Up to $30	100% Covered	Up to $25	
Bifocal Lenses	100% Covered	Up to $50	100% Covered	Up to $40	
Trifocal Lenses	100% Covered	Up to $65	100% Covered	Up to $55	
Progressive Lenses	$55-$175	Not Covered	$65	Not Covered	
Network	VSP Choice Network offers over 60,700 access points with an additional 11,400 access points at nearly 4,500 retailer locations nationwide		EyeMed Vision Care Access Network offers more than 80,100 access points at nearly 7,000 retail locations		Members select the vision provider of their choice, pay the provider and submit a claim for reimbursement. Because there's no network, members may take advantage of special pricing offers from the provider. Plan includes 15% off prescription eyeglasses purchased at Walmart Vision Center (excludes contacts). Visit Walmart.com to see what's available near you.
Find a Provider	800-877-7195 vsp.com		866-289-0614 eyemed.com		
Network Savings	20% off remaining balance on frames and additional non-covered complete prescription glasses. 20-25% off non-covered lens options such as UV coating and polycarbonate lenses. Average 15% off usual and customary price, or 5% off promotional price, for LASIK or PRK through VSP and a contracted laser surgery center.		20% off remaining frame balance and materials not covered by plan (excludes lens upgrades). 40% off complete pair prescription glasses after plan benefit. Special pricing on lens upgrades such as UV coating and polycarbonate lenses. 15% off retail price, or 5% off promotional price, for LASIK or PRK with US Laser Network.		

Member Savings

You may receive additional savings that can reduce out of pocket expenses:

Save on prescription medications through any Walmart or Sam's Club pharmacy (membership at Sam's Club not required).

Access to emergency vision provider referrals when traveling outside the U.S. through AXA Assistance.

Additional Information

Eligible Employees: An individual employed by a participating employer who works 20 hours or more per week, and who is considered an employee for Social Security purposes. Partners and Proprietors are also considered to be eligible employees.

Dependents: A spouse or domestic partner, or dependent child under age 26.

Eligible Dependent: An unmarried child at least 26 years of age who relies on you for support because he or she is incapable of self-sustaining employment due to mental or physical incapacity.

Network Discounts: Based on applicable laws, reduced costs may vary by doctor location for VSP and EyeMed plans.

What is not covered?

VSP® Limitations

Please check for availability in your state. Based on applicable laws, reduced costs may vary by doctor locations. Covered expenses will not include and no benefits will be payable for:

- Vision examinations, lenses and frames more than the frequency as indicated on the plan summary page.
- Services and/or materials not specifically included in the Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section of the Plan Benefits.
- Services or materials that are cosmetic, including plano contact lenses to change eye color and artistically painted contact lenses.
- Two pairs of glasses in lieu of bifocals.
- Replacement of spectacle lenses, frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens modification, polishing or cleaning.
- The refitting of contact lenses after the initial 90-day filing period.
- Contact lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Local, state and/or federal taxes, except where law requires us to pay.
- Covered persons may be required to purchase a membership at certain retail locations before accessing plan benefits.

EyeMed Limitations

Please check for availability in your state. Based on applicable laws, reduced costs may vary by doctor locations. Covered expenses will not include and no benefits will be payable for:

- Vision examinations, lenses and frames more than the frequency as indicated on the plan summary page.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section of the Plan Benefits.
- Two pairs of glasses in lieu of bifocals.
- Replacement of spectacle lenses, frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.

Non-network Limitations

Please check for availability in your state. Based on applicable laws, reduced costs may vary by doctor locations. Covered expenses will not include and no benefits will be payable for:

- Vision examinations, lenses and frames exceeding the set annual benefit amount.
- Examinations performed or frames or lenses ordered before the member was covered under the plan.
- Subject to extension of benefits, any examination performed or frame or lens ordered after the coverage under the plan ceases.
- Sub-normal eye care aids; orthoptic or eye care training or any associated testing.
- Non-prescription lenses.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.
- Medical or surgical treatment of the eyes.
- Any service or supply not shown on the Schedule of Eye Care Procedures.
- Coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.
- Claims filed more than 90 days after completion of the service (or longer than 90 days in certain states). An exception is if the Insured shows it was not possible to submit the proof of loss within this period.

Contact name

Contact info

 | star.ameritas.com | 855-728-7542

GemStar Flex Vision

Rates effective *August 1, 2016*

Choose your vision rate based on total number of enrolled employees, then multiply by # of employees to determine premium

Network	Coverage Type	2-9 Enrolled	10+ Enrolled	# of Employees		Subtotal
VSP	Employee Only	$10.24	$9.12	x	=	$
	Employee + Spouse	$22.16	$19.68	x	=	$
	Employee + Child(ren)	$17.88	$15.92	x	=	$
	Employee + Family	$29.80	$26.48	x	=	$
EyeMed	Employee Only	$8.60	$7.52	x	=	$
	Employee + Spouse	$19.24	$16.76	x	=	$
	Employee + Child(ren)	$15.60	$13.60	x	=	$
	Employee + Family	$26.24	$22.84	x	=	$
Non-Network	Employee Only	$8.60	$7.52	x	=	$
	Employee + Spouse	$19.24	$16.76	x	=	$
	Employee + Child(ren)	$15.60	$13.60	x	=	$
	Employee + Family	$26.24	$22.84	x	=	$
				Total Vision Premium for Group		$

VSP is not available in MA or RI.
EyeMed is not available in RI.
Rates are for groups with 2-99 employees.

application Group Dental and/or Eye Care Insurance

Ameritas Life Insurance Corp. P.O. Box 81889, Lincoln, NE 68501-1889

Ameritas

See reverse side for additional information

1. **Applicant's Legal Name** _____

2. **Doing business as** _____

3.

_____
P.O. Box / ZIP Code

_____
Street Address

_____
City / State / ZIP

_____
Phone No. Fax No.

_____
E-mail Address Tax I.D. No.

4. **What is the nature of your business or industry?**

_____

5. **Eligibility**

Total Number of Eligible Employees . . . . . _____

Employees in Waiting Period . . . . . _____

6. **Are any classes or locations excluded?** . . . . . ☐ Yes ☐ No

Are domestic partners included? . . . . . ☐ Yes ☐ No

Are retirees included? . . . . . ☐ Yes ☐ No

(If yes, please use reverse side for explanation.)

7. **Are any subsidiary and/or affiliated companies to be insured?** . . . . . ☐ Yes ☐ No

(If yes, please use reverse side to list name and location.)

8. **How many hours per week equals full time employment?** . . . . . _____

9. **Employee Participation**

Employer contributes _____% of employee premium.

☐ **Tied-to-Medical** (All employees covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all employees must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

10. **Dependent Participation:**

Employer contributes _____% of dependent premium.

☐ **Tied-to-Medical** (All eligible dependents covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All eligible dependents must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all eligible dependents must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

11. **Section 125 Plan**

Election Period _____

Plan Year _____

12. Employee welfare benefit plans that are subject to ERISA must satisfy various reporting, disclosure and related obligations. These requirements include the provisioning of a Summary Plan Description or SPD. The certificate of coverage can serve as an SPD if certain information is additionally disclosed. Please check one of the following (failure to respond shall be considered a positive response for A. and a negative response for B.).

A. ☐ **Plan is subject to ERISA (complete question 12.B.)**

☐ **Plan is NOT subject to ERISA — Church or Govt. employer or other safe-harbor exception** (see DOL Reg. §2510.3-1(j))

B. ☐ **Applicant requests that Ameritas Life Ins. Corp. prepare a SPD for its dental and/or vision plan** . . . . . ☐ Yes ☐ No

If yes, the company is to prepare a SPD. The following information is required under ERISA and MUST be included in the SPD.

Plan No. _____ Plan Fiscal Year End Date _____

Plan Administrator:

Name: _____

Address: _____

City, State, ZIP _____

Phone No. _____ Plan Fiscal Year _____

Please Note: Applicant remains responsible for **ensuring** that SPD form provided by Ameritas Life Insurance Corp. is complete and accurate and satisfies applicable laws and regulations. Moreover, applicant remains responsible for providing its plan participants with SPD updates as required by applicable law and regulations.

13. Waiting Period

_____ for those employed on or before the policy effective date.

_____ for those employed after the new policy effective date.

☐ month(s) ☐ calendar days ☐ working days

14. Effective Date and Termination Date

☐ Immediate

☐ First of Month Effective date / End of Month Termination date

☐ Other

15. Premium Payment Mode (In advance)

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ Payroll Deduction (To choose this option, employee must pay employee and dependent premium.)

If policy effective date is other than first of the month, is a first of the month premium due date desired? . . . ☐ Yes ☐ No

Billing Options

☐ Home Office ☐ Third-Party Administration

_____
Contact Name

_____
Title

_____
Street Address

_____
City / State / ZIP

_____
Phone No. Fax No.

_____
E-mail Address

16. The following coverages are applied for:

Employee & Dependents Benefits

☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

Employee Only Benefits

☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

This insurance shall be effective on: _____
(Premiums due prior to the coverage period.)

17. Policy and Certificate Delivery (select one)

A. eCert*/ePolicy (*generic cert, non-personalized)

☐ via PDF format sent via e-mail to:

_____

☐ via eService and member portal

B. Paper policy/personalized certificates

☐ Initial employees only

☐ Subsequently added employees

Note: eCert will be available on member portal for all members.

18. Insurance requested on this application will replace the coverage(s) checked.

Coverages: ☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

Name of Current Carrier _____

Policy No. _____

☐ Coverage applied for is replacing comparable coverage now or previously in force with another carrier.

_____
Termination Date Original Effective Date

Item 6: Exclusions

a. Classes, include reason for exclusion.

b. Locations, if location is different from applicant's, list city and state.

Item 7: Subsidiary and/or affiliated companies to be insured. List names and locations.

Plan Design and Proposed Rates:

Additional Remarks:

Agreements

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 and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders 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., group insurance at the Company's rates and 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.

Statements

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. (See state-specific statements.)

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 group 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 figura en su tarjeta de identificación 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 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 Insureds: 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note for Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

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.

Note for Washington, 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 Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

☐ **If you do not want your company name used by Ameritas Life Insurance Corp. in our effort to recruit Network providers, check this box.**

Signed at: City_____ State_____ Date_____

Signed by: (Policyholder Representative)

Printed name and title _____

Signature _____

Soliciting Agent: I understand and agree that if I'm not already appointed with Ameritas Life Insurance Corp., I must apply to and be appointed with Ameritas before I present this product to any client.

Printed Name_____ For FL agents only, provide FL license #_____

Signature _____

The policy provides dental and/or vision benefits only. Review your policy carefully.

Was a binder check received? ☐ Yes ☐ No If yes, then amount $_____.

Check received by (agent)_____ **Authorized by** (policyholder)_____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AMERITAS LIFE INSURANCE CORP.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Ameritas

Policy and Div. # **010-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ Eye Care ☐ To terminate all coverages

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 add	Dental drop	Eye Care add	Eye Care drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐	☐	☐					☐
2	☐	☐	☐	☐					☐
3	☐	☐	☐	☐					☐
4	☐	☐	☐	☐					☐
5	☐	☐	☐	☐					☐

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 _____ _____

Employee Signature (do not print) **Date**

X _____ _____

Policyholder Signature (do not print) **Date**

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 on back.)

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

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.

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 group 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 figura en su tarjeta de identificación o al 877-233-3797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

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

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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.

Note for Washington, 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 Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

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.