



GemStarSM 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

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		
Find a Provider	800-877-7195		866-289-0614		
	vsp.com		eyemed.com		
Network Savings	<p>20% off remaining balance on frames and additional non-covered complete prescription glasses.</p> <p>20-25% off non-covered lens options such as UV coating and polycarbonate lenses.</p> <p>Average 15% off usual and customary price, or 5% off promotional price, for LASIK or PRK through VSP and a contracted laser surgery center.</p>		<p>20% off remaining frame balance and materials not covered by plan (excludes lens upgrades).</p> <p>40% off complete pair prescription glasses after plan benefit.</p> <p>Special pricing on lens upgrades such as UV coating and polycarbonate lenses.</p> <p>15% off retail price, or 5% off promotional price, for LASIK or PRK with US Laser Network.</p>		

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.



This information is provided by Ameritas Life Insurance Corp. (Ameritas Life). Group dental, vision and hearing care products (9000 Rev. 03-16, dates may vary by state) and individual dental and vision products (Indiv. 9000 Ed. 07-16, dates may vary by state) are issued by Ameritas Life. Some plan designs are not available in all areas. Some states require that producers be appointed with Ameritas Life before soliciting its products.

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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.

Email completed worksheet, Employer Application and Employee Enrollment Forms to:

GemStarBrochure@ameritas.com

Questions? Call 402-309-2032

TO BE COMPLETED BY WRITING AGENT					
Group Information					
Group Name				Telephone Number	
Address			City	State	Zip
Effective Date		Total Eligible Lives		Takeover <input type="checkbox"/> Yes <input type="checkbox"/> No	
Elite Dental					
Dental Plan <input type="checkbox"/> 1500 <input type="checkbox"/> 1000+		ER Contribution for EE Only \$		Total Enrolled Lives	
Sold Rates:	Employee \$	Employee + Spouse \$	Employee + Child(ren) \$	Employee + Family \$	
Flex Vision					
Vision Plan <input type="checkbox"/> VSP <input type="checkbox"/> EyeMed <input type="checkbox"/> Non-Network		ER Contribution for EE Only \$		Total Enrolled Lives	
Sold Rates:	Employee \$	Employee + Spouse \$	Employee + Child(ren) \$	Employee + Family \$	
Writing Agent Information					
Name			Telephone Number		
Agency Name (if applicable)					
Appointed with Ameritas? <input type="checkbox"/> Yes <input type="checkbox"/> No, If no, appointment forms are attached					
TO BE COMPLETED BY GENERAL AGENT					
GA Name			Telephone Number		
GA Agency Name (if applicable)					
Commissions: Writing Agent %		Other %		GA %	
WRITING AGENT/GENERAL AGENT SPECIAL INSTRUCTIONS OR NOTES					
AMERITAS USE ONLY:					
Ameritas Sales Representative:					
Special Instructions or Notes:					
Completed By				Date	

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.

EFT Form

Electronic Funds Transfer Authorization



Ameritas Life Insurance Corp. P.O. Box 82669 / Lincoln, NE 68501 / 800-659-2223 / Fax: 402-467-7338

Request and Authorization for Bank Payment Plan

It's the simplest method of paying your premium. No more checks to write! It's automatic and reliable. We call it electronic funds transfer (EFT for short). It allows for peace of mind however you do business — whether it's online or through the mail.

Online: Groups that receive invoices online, you have the freedom to choose when we debit your account. When you're ready, just visit our website, ameritas.com, sign into your secure account and click PAY BILL. We'll draft your premium payment right away.

Mail: Groups that receive their invoices through the mail, just authorize us to debit your account each month and we'll do the rest. It's the forget-proof method of paying your premium.

Authorized Agreement for Prearranged Payments (Debits)

Group Policy # _____ Phone # _____

Policyholder Name _____

Policyholder Contact _____

- New Authorization Change of Account
 Checking Account Savings Account

I hereby authorize Ameritas to initiate debit entries to the account number listed below, and at the bank named below, herein called BANK, to debit the same to such account. The EFT draft will be monthly or quarterly, whichever payment option was selected, on or about the first day of the coverage period.

Bank Account Number _____ Bank Routing Number (9 digits) _____

Bank Name _____

Account Name _____

Address _____

City _____ State _____ ZIP _____

Phone Number of Financial Institution _____

To ensure a timely and effective setup, it is necessary to send a voided check with this request.

This authorization is to remain in full force and in effect until BANK has received written notification of its termination in such time and such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first.

Name (print)

Title of Authorized Signer

X

Signature

Date

Federal Tax ID#

Please keep a copy of this form for your records.

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.

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.

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.