

**Enroll Now  
in a Great  
Dental Offer!**

Exclusive Offer for



Members

**Hurry Enroll  
Today!  
1-877-473-6031**

FOR NEVADA, NEW JERSEY AND MASSACHUSETTS RESIDENTS ONLY

### ABOUT AMERITAS

Ameritas Group, a division of Ameritas Life Insurance Corp., provides dental and eye care coverage for more than 49,000 employer groups, insuring more than 4 million people nationwide. Founded in 1887, Ameritas Life earns high ratings from independent insurance industry analysis:

- A (Excellent)–A.M. Best Company. For financial strength and operating performance. The third highest of Best’s 15 ratings.
- AA- (Very Strong)–Standard & Poor’s. For insurer financial strength. The fourth highest of S&P’s 21 ratings.

The company’s state of the art electronic dental claims system processes over 2.5 million claims each year with a customary turn around time of 5-10 working days, far faster than the industry average.

### DENTAL REWARDS®

Only Plan 1 includes the exciting feature of Dental Rewards. This feature rewards insureds who visit the dentist and use only a specified portion of their annual maximum benefit in a year. With its increasing annual maximum feature, each insured employee and dependent earns additional money towards his/her next year’s annual maximum.

Annual Maximum for Preventive, Basic and Major Procedures	<b>\$ 1000</b>
Annual Benefit Threshold (not exceeding this amount)	<b>\$ 500</b>
Annual Carry Over/Reward Towards Next Benefit Year	<b>\$ 250</b>
Next Benefit Year’s Annual Max Plus Carry Over/Reward	<b>\$ 1250</b>
Maximum Carry Over/Reward (additional accumulation toward annual maximum)	<b>\$ 1000</b>

Insured members have the freedom to choose any dentist. Voluntary use of the Ameritas network can reduce costs and eliminate balance billing. To look up a dentist, simply go to:

[www.ameritasgroup.com/provider/dental.htm](http://www.ameritasgroup.com/provider/dental.htm).

Benefit exclusions and limitations apply to this dental benefit plan, which is underwritten by Ameritas Life Insurance Corp. Covered Expenses will not include and no benefits will be payable for expenses incurred:

#### All Plans

■ for any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the second bicuspid are considered cosmetic. ■ for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the plan member is covered under the dental expense benefit. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth. ■ for any procedure begun before the plan member was covered under the dental expense benefit. ■ for any procedure begun after the member’s insurance under the dental expense benefit terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the member’s insurance under the dental expense benefit terminates. ■ to replace lost or stolen appliances. ■ for appliances, restorations, or procedures to: • alter vertical dimension; • restore or maintain occlusion; • splint or replace tooth structure lost because of abrasion or attrition. ■ for any procedure which is not shown on the Table of Dental Procedures. ■ for which the plan member is entitled to benefits under any workmen’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit. ■ for charges for which the plan member is not liable or which would not have been made had no insurance been in force. ■ for services which are not required for necessary care and treatment or are not within the generally accepted parameters of care. ■ because of war or any act of war, declared or not. ■ for any procedure except exams, cleaning and fluoride applications for the first 24 months when a member or dependent becomes classified as a late entrant. If a member or dependent does not enroll within 31 days from the date the person qualifies for the insurance or who elected to become covered again after canceling a premium contribution agreement will be classified as a late entrant. ■ to replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within ten years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the person is covered, it will be a Covered Expense.

Marketed and Administered by:  
**HealthPlan Services**

Insured by:  
**AMERITAS GROUP**

We’re Ameritas. We’re for people.®

A Division of Ameritas Life Insurance Corp.  
A UNIFI Company

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**INTRODUCING A DENTAL PLAN WITH BIG BENEFITS.**

Thanks to the purchasing power of ASA, members can now benefit from the kind of quality dental coverage and pricing typically reserved for large groups. The program, administered by HealthPlan Services, was specifically designed for ASA and its members by Ameritas Life Insurance Corp. and is underwritten by Ameritas Life, one of the leading dental carriers in the nation.

COVERAGE	MONTHLY PREMIUM		
	Plan 1	Plan 2	Plan 3
Member	\$49.96	\$34.72	\$29.96
Member + 1	\$96.68	\$67.16	\$59.56
Member + 2 or more	\$139.80	\$97.08	\$86.12
<b>DENTAL PLAN DESIGN</b>			
<b>TYPE 1 PREVENTIVE</b> NO DEDUCTIBLE, NO ELIMINATION PERIOD	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Evaluations</b> Once every six-month period			
<b>Cleanings</b> Allowed once in a six-month period			
<b>Fluoride for Children</b>			
<b>Radiographs</b> X-rays			
<b>Bitewings</b>			
<b>Sealants</b> (Plans 1 and 2 only)			
<b>TYPE 2 BASIC</b> \$50 CALENDAR YEAR DEDUCTIBLE, NO ELIMINATION PERIOD	<b>80%</b>	<b>80%</b>	<b>80%</b>
<b>Restorative Amalgams</b>			
<b>Oral Surgery</b> Simple Extractions			
<b>Denture Repair</b>			
<b>Sealants</b> (Plan 3 only)			
<b>TYPE 3 MAJOR</b> \$50 CALENDAR YEAR DEDUCTIBLE, NO ELIMINATION PERIOD	<b>50%</b>	<b>25%</b>	<b>N/A</b>
<b>Oral Surgery</b> Complex Extractions			
<b>Anesthesia</b>			
<b>Crowns</b>			
<b>Endodontics</b> Root Canals			
<b>Periodontics</b> Gum Disease			
<b>Prosthodontics</b> Fixed Pontics or Abutments Removable Dentures, Partials			
<b>Internal Maximum</b> (only applies to Type 3)	<b>N/A</b>	<b>Eligible benefits up to \$500</b>	<b>N/A</b>
<b>ANNUAL MAXIMUM</b>	<b>\$1000 + DENTAL REWARDS®</b>	<b>\$1000</b>	<b>\$1000</b>

**CLAIM ALLOWANCES FOR COVERED PROCEDURES**

**IN-NETWORK BENEFITS**  
Contracted Fees

**OUT-OF-NETWORK BENEFITS**  
50th U&C

- 50th U&C: Benefits for a covered dental procedure are paid according to the Usual & Customary charge for that procedure within a particular ZIP Code area. Out-of-Network benefits are calculated at the 50th percentile of U&C, which means 5 out of 10 dentists in a specific area charge at or below the plan allowance for a procedure.
- Claim allowances are revised annually and are subject to change throughout the year, possibly resulting in minor adjustments to claim allowances and out-of-pocket costs.



# Enrollment Form For Dental Insurance Program

Insured by Ameritas Life Insurance Corp.  
Administered by HealthPlan Services

**Enrollment Form From:**  
**Ameritas Life Insurance Corp.**  
c/o ASA/HPS  
P.O. Box 30474, Tampa, FL 33630-3474

Is this application for:  New Business (first time applicant)  
 Change to existing policy  
Current policy number \_\_\_\_\_

(Answer ALL questions completely).

CURRENT MEMBER OF ASA   
MEMBERSHIP NUMBER \_\_\_\_\_ (required for all applicants)

## SECTION 1: APPLICANT INFORMATION

NAME OF PRIMARY APPLICANT (Last, First, MI)

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  MALE  MARRIED  DIVORCED  
 FEMALE  SINGLE  WIDOWED

PRIMARY APPLICANT'S ADDRESS (P.O. Boxes are not accepted)

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE NUMBER (Work) \_\_\_\_\_ PHONE NUMBER (Home) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

## SECTION 2: DENTAL PLANS

ARE YOU COVERED FOR DENTAL INSURANCE UNDER ANOTHER PLAN?

**APPLICANT**  YES  NO **DEPENDENT**  YES  NO

REQUESTED EFFECTIVE DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SELECT PLAN** (Choose 1 of the 3 plans)  PLAN 1  PLAN 2  PLAN 3

**COVERAGE** (Applied for)

APPLICANT ONLY  
 APPLICANT PLUS ONE DEPENDENT  SPOUSE OR  CHILD  
 APPLICANT PLUS TWO OR MORE DEPENDENTS  SPOUSE AND/OR  CHILDREN

## SECTION 3: BILLING INFORMATION

### PAYMENT METHOD

- MONTHLY EZ PAY — ONE MONTH PREMIUM REQUIRED (No administration fee) Complete Section 4
- MONTHLY BILLING OPTION — ONE MONTH PREMIUM REQUIRED (plus \$3 monthly administration fee)
- QUARTERLY BILLING OPTION — THREE MONTHS PREMIUM REQUIRED (plus \$3 quarterly administration fee)
- SEMI-ANNUAL BILLING OPTION — SIX MONTHS PREMIUM REQUIRED (plus \$3 semi-annual administration fee)
- ANNUAL BILLING OPTION — TWELVE MONTHS PREMIUM REQUIRED (plus \$3 annual administration fee)

### TOTAL PAYMENT INCLUDING ADMINISTRATION FEE WITH APPLICATION REQUIRED

Make Check Payable to Ameritas Life Insurance Corp.

**SECTION 4: EZ PAY AGREEMENT (Complete only if you selected monthly EZ pay option)****EZ PAY AGREEMENT**

PAYOR NAME OR DEPOSITOR IF DIFFERENT	RELATIONSHIP TO APPLICANT
NAME OF FINANCIAL INSTITUTION	CHECKING/SAVINGS ACCOUNT NUMBER

ADDRESS

CITY

STATE

ZIP CODE

SPECIFY TYPE OF ACCOUNT

 CHECKING SAVINGS

SIGNATURE: X \_\_\_\_\_

DATE: / /

ABA 9 DIGIT ROUTING NUMBER (SEE BELOW OR PLEASE CALL YOUR FINANCIAL INSTITUTION FOR ASSISTANCE)

Ameritas Life Insurance Corp. ("Ameritas") and/or HealthPlan Services, acting as Plan Administrator on behalf of Ameritas, is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month. I understand that premiums already paid will be refunded to me if my Certificate is not issued. I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by Ameritas and/or HealthPlan Services, and I agree that the bank named shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify HealthPlan Services in writing.

<b>ATTACH YOUR INITIAL CHECK OR MONEY ORDER FOR PREMIUM PAYMENT</b>		1117
Joe Smith 123 Main Street Anytown, IL 12345		
		Date _____
Pay to the order of AMERITAS LIFE INSURANCE CORP.		\$ _____
		Dollars
For _____		
Routing Number _____		
①23456789② 1234567891011 1117		

<b>EZ PAY PLAN APPLICANTS ONLY</b>
<b>Voided Check</b>
(Deposit Slips are not acceptable)

**SECTION 5: CONTRACT****PLEASE SIGN AND 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.

■ 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 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. ■ 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 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 Kansas, Nebraska, Oregon 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 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: The master insurance policy providing coverage is governed by the laws of Georgia.

As a member/employee, I hereby apply for insurance. These benefits were 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.

ASA Member Signature X \_\_\_\_\_ Date \_\_\_\_\_  
(required)

Agent Name \_\_\_\_\_ FL License # \_\_\_\_\_

**Once completed, signed and dated, mail this form along with your premium payment to:**

**ASA/HPS, P.O. Box 30474, Tampa, FL 33630-3474, Phone: 1-877-473-6031**