# Enrollment/Change/Waiver Group Insurance Form

Ameritas Life Insurance Corp. of New York 1350 Broadway, Suite 2201 / New York, NY 10018 / 1-800-628-8889

Ameritas

Policy and Div.# 026- _____

Cert. # _____

| **COBRA:** If individual is a continuee: | Qualifying Event | Date of Event |
|---|---|---|
| | | |

Name and Address of Employer (Policyholder) Cayuga-Onondaga BOCES, 1879 West Genesee Street Rd. Auburn, NY, 13021

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

Select Plan: ○ High ○ Middle ○ Low

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 _____

Email 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 x Policyholder's records.

X _____ _____

Employee Signature (do not print) Date

X _____ _____

Policyholder Signature (do not print) Date

Any person who knowingly and with intent to defraud any insurance company or other reason 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 shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.

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.

## 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.