2019 Plan Year

WILKINSON COUNTY

DENTAL PLAN

- Coverage for Employees, Spouses, and Children up to age 26.
- Orthodontia for children and adults.
- To find network providers, visit www.Ameritas.com

Coinsurance	
Preventive - Type 1	100% - NEW!
Basic - Type 2	80%
Major - Type 3	50%
Orthodontics	50%

Monthly Rates	
Employee Family	$32.08 $88.32

Dental Benefits Summary	
Calendar Year Deductible	$50/person $150/family Waived for Type 1
Out of Network Coverage	90th percentile UCR
Waiting period	None
Calendar Year Plan Maximum	$1,000 per person per year
Orthodontia (Lifetime)	$1,500 per person

Benefit Overview	
Type 1: Preventive - 100% - NEW!	
Routine Exam (2 per benefit period)	Periapical X-Rays
Cleaning (2 per benefit period)	Sealanta (children under age 17)
Fluoride (children under age 19)	Full Mouth X-rays (1 in 3 years)
Bitewing X-rays (2 per benefit period)	Space Maintainers
Type 2: Basic - 80%	
Restorative Amalgams	Restorative Composites
Endodontics	Periodontics
Denture Repair	Anesthesia
Simple and Complex Extractions	
Type 3: Major - 50%	
Onlays Crown Repair Crowns (1 in 5 years per tooth)	Prosthodontics (Fixed Bridge, removable complete/partial dentures) (1 in 5 years)

Dental Rewards	
Annual Carryover Amount	$250 - Dental Rewards amount is added to the following year's maximum. (Maximum accumulation is $1,000)
Benefit Threshold	Dental benefits received for the year cannot exceed $500.

**The above is an overview for illustration purposes. Please see policy for full details.*

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

Policy and Div. # **010-** 350551 - 00008

Cert. # ____________________

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

Name and Address of Employer (Policyholder) Wilkinson County Board of Education

1 to enroll ☐ Dental ☐ 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

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

Please Sign (employee/policyholder) **The certificate provides dental 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 ____________ X ____________

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