KY Individual Plan Enrollment Form

DentalSelect

Use the Individual Enrollment Form to collect first time subscriber and dependent information.
For existing member changes, please use the Change Form.

Choose Your Plan

☐ Coinsurance (Platinum Network) ☐ Coinsurance Plus (Platinum Network)

☑ EyeMed Discount Vision Program Included

Subscriber Details

SSN – –	Date of Birth (MM/DD/YYYY) / /	
First Name	M.I.	Last Name
Address		
City	State	Zip Code
Phone #		Gender ☐ Male ☐ Female
Email Address		
Requested Effective Date (MM/DD/YYYY) / /		
Agent Name		
Agent Number	Agent Phone Number – –	

Dependent Details

Spouse Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN – –	Date of Birth / /	

Dependent Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN – –	Relationship	Date of Birth / /

Dependent Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN – –	Relationship	Date of Birth / /

Dependent Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN – –	Relationship	Date of Birth / /

Dependent Name (Last, First, M.I.)		Gender ☐ Male ☐ Female
SSN – –	Relationship	Date of Birth / /

For additional dependents, please attach separate sheet.

Billing Infomation (Choose either Checking/Savings or Credit Card Payment)

Billing Period: ☐ Monthly (Withdrawn on the 15th or next 2 business days)
☐ Annual (Check or Credit Card)
Is this insurance intended to replace any other accident and health insurance presently in force? ☐ Yes ☐ No

Checking or Savings

☐ Checking Account (Include Voided Check)	☐ Savings Account (Include Deposit Slip)
Financial Institution:	
Routing Number:	
Account Number:	

Credit Card Payment

☐ VISA ☐ MASTERCARD

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date: ☐☐/☐☐

Account Holder Name:

Account Holder Signature: _____ Date: _____

Authorization of Coverage

I wish to enroll in the plan I have selected. I authorize and agree to account deduction of the required premium.

I have read the statements and answers to the above questions and they are complete and true to the best of my knowledge and belief. All statements are deemed to be representations and not warranties.

This authorization will appear on my statement as "Dental Select" as authorized by Ameritas Life Insurance Corp. and remain in effect until the financial institution has received and has had reasonable time to act on a written request from me to terminate this agreement. I understand that I can stop a withdrawal by notifying the financial institution, per their cancellation guidelines, before the withdrawal is made. In the event of a withdrawal error, I must promptly notify the financial institution to preserve any rights I may have. Please direct billing inquiries to the policy administrator: Dental Select, 75 W Towne Ridge Parkway, Tower 2, Suite 500, Sandy, UT 84070, as authorized by Ameritas Life Insurance Corp. I have read and understand the statements above pertaining to the billing option. Your cancellation will be effective the first day of the month following the month your written request is received.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER OR ANY OTHER PERSON. PENALTIES MAY INCLUDE IMPRISONMENT AND/OR FINES AND MAY BE GUILTY OF INSURANCE FRAUD AS DETERMINED BY A COURT OF LAW. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

In the event there are insufficient funds when a draft is charged to my account, I agree to pay $25 NSF Fee. The 3rd returned check in any 12 month period will result in the immediate cancellation of my policy. Dental Select reserves the right to deny me the ability to be reinstated on any personal Dental Select plan for two years based on NSF or credit card declinations.

Signature: _____ Date: _____

The policy provides limited benefits. Review your policy carefully.

Please fill out and return this Enrollment Form with your payment to:

Enrollment Department
PO Box 26203
Salt Lake City, UT 84126

Phone: 800-999-9789
Fax: 888-998-8711
dentalselect.com