FLEXIBLE BENEFITS
GROUP ENROLLMENT OR WAIVER FORM

AMERITAS LIFE INSURANCE CORP.

PLEASE PRINT IN BLACK INK

POLICY AND DIV. # **010-350551-1** CERTIFICATE / MEMBER # _____ DEPT. # _____

NAME OF EMPLOYER **OCONEE RESA**

EMPLOYEE LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

EMPLOYEE'S STREET ADDRESS _____

CITY, STATE, ZIP _____

EMPLOYEE ID # _____ DATE OF BIRTH _____ ❑ MALE ❑ FEMALE

FULL-TIME EMPLOYMENT DATE _____

JOB TITLE _____ AVERAGE HOURS WORKED PER WEEK _____

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

DENTAL COVERAGE REQUESTED

PLAN 1 ❑ Employee Only ❑ Employee and Family

POLICYHOLDER'S STATEMENT
The date of employment, job title and hours worked have been verified as being correct according to the Policyholder's records.

By _____
For the Policyholder

I hereby apply for 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.

I am signing up for coverage until the next enrollment period except in the case of a change in family status. This information was explained in the plan's solicitation materials which I have read and understand.

_____ _____
Employee Signature (Do Not Print) Date Signed

WAIVER OF COVERAGE

I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided to:

WAIVE DENTAL COVERAGE FOR: ❑ myself ❑ family

because _____

_____

Name of Insurance Co. & Employer of Dependent _____
Should I desire to apply for dental insurance in the future, I realize that a "late entrant" penalty may be applied.

_____ _____
Employee Signature (Do Not Print) Date Signed

CODE	REC. CODE	EFFECTIVE DATE	CLASS	DEP. CODE				
	21							

EMPLOYEE LATE ENTRANT DATE _____ DEPENDENT LATE ENTRANT DATE _____