Spirit DENTAL & VISION

PERSONAL INFORMATION

First Name	Middle	Last Name

Home Phone ( ) -	Birth Date Month: _____ Day:_____ Year: _____
Gender [ ] Male [ ] Female	Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Email	[ ] Yes, please send me news and updates
Address	

City	State	Zip

Do you have any dental or vision insurance currently in force?	[ ] Yes	[ ] No
Is the insurance applied for intended to replace any existing insurance?	[ ] Yes	[ ] No
I confirm I have read the Outline of Coverage	[ ] Yes	[ ] No

PAYMENT INFORMATION

Name on Card	Credit Card Number - - -
Exp Date Month _____ Year_____	[ ] I have read and agree to the Authorization Agreement, Limitations and Exclusions and Important Fraud Notices. By submitting your enrollment you hereby apply for coverage under Individual Dental Policy Form Indiv. 9000 Rev. 07-16 and/or Vision Policy Form Indiv. 9000 Ed. 07-16-V. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued.
Monthly Total:	[ ] One Time Enrollment Fee: $25
Total Amount Charged	

Authorization Agreement

I authorize Ameritas Life Insurance Corp. to initiate electronic debit entries to my account chosen above for payment of my insurance premium. I certify that I am an authorized user on the above listed account. I acknowledge that debits to my account for premium due will occur on a regular recurring basis based on the payment frequency indicated above until such time as coverage terminates or until I notify Ameritas to terminate these transactions. I understand that it may take up to two weeks to process a request to discontinue recurring payments. In order to make changes to this authorization (such as change in bank account, method of payment, or termination of payment) I must provide Ameritas at least two weeks' notice in advance of the next scheduled payment date.

Payment Information:

1. Initial premium will be withdrawn within 3 days of your policy effective date; subsequent premiums are due on the day of the month in which the policy was effective.

2. I authorize Direct Benefits, Inc., dba Spirit Dental to initiate the electronic debit entry to my account for the one-time non-refundable enrollment fee of $25 to my account chosen above. I certify that I am an authorized user on the above listed account. This charge will be made at the time of purchase and will appear as a separate transaction from the insurance.

For initial payments I acknowledge that Ameritas may debit my account upon acceptance and approval of my application. Based upon my authorization, Ameritas will process reoccurring payments on or within three business days of the date of the month in which my policy was first effective.

If any authorized payment is returned or dishonored by my bank, I acknowledge that I am responsible for any fees my bank may charge. I understand also that I may incur a return payment fee of $25 charged by Ameritas if the return is due to insufficient funds. I acknowledge that such a fee, if charged, may be automatically debited from my authorized account on the next payment date. I am responsible for remitting payment within the policy grace period. If payment is not received by Ameritas within the defined grace period I acknowledge that my coverage may be cancelled in accordance with the terms of the insurance contract.

I also acknowledge that I have read the following information from Ameritas regarding this electronic signature.

If applicable, I consent to receiving my Policy, Outline of Coverage and any other plan information electronically and I electronically affirm of my consent to do so. I understand I need internet access and that I can withdraw my consent at any time per the notification instructions below, I understand I can receive any of the documents in paper form if I choose.

- I may return my policy within the right-to-cancel period as described in my policy;

- I acknowledge receipt of the Outline of Coverage (in states where required by law);

- I understand the policy I am applying for provides dental and (if chosen) vision benefits only and is not a Medicare supplement;

- I acknowledge that the agent of record, if applicable, is my insurance agent for purposes of the Ameritas Privacy Policy; and

- I understand that it is my responsibility to give notice to Ameritas of changes in my email address or any information above, as well as my status and my family's status that effect coverage, such as marriage, births, or death of someone covered under the policy. I will provide notice via email at adminserv@employeeBenefitservice.com, fax at 402-467-7338 or in writing to Ameritas or its designee: PO Box 81889, Lincoln, NE 68501.

You are encouraged to print a copy of your electronic forms to retain for your own records. The computer hardware and software necessary to access your electronic forms are a personal computer with a Windows or Macintosh operating system. You will be notified by mail if there is ever a change in the hardware or software requirements for accessing your electronic forms.

Limitations and Exclusions

Dental Expenses will not include, and benefits will not be payable, for any of the following:

• Covered Dental Expenses for appliances, restorations, or procedures to do any of the following: - Alter vertical dimension. - Restore or maintain occlusion. - Splint or replace tooth structure lost as a result of abrasion or attrition.

• Covered Dental Expenses for any procedure begun after the insured person's insurance under this contract terminates.

• Covered Dental Expenses to replace lost or stolen appliances.

• Covered Dental Expenses for any treatment which is for cosmetic purposes.

• Covered Dental Expenses for any procedure not shown in the Table of Dental Procedures. (Frequency and other limitations may apply. Please see the Table of Dental Procedures for details.)

• Covered Dental Expenses for orthodontic treatment unless orthodontic expense benefits have been included in this policy. Please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision.

• Covered Dental Expenses for which the Insured person is entitled to benefits under any workers' 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 employment (unless prohibited by state regulations).

• Covered Dental Expenses for charges which the Insured person is not liable or which would not have been made had no insurance been in force, except for those benefits paid under Medicaid.

• Covered Dental Expenses for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

• Covered Dental Expenses because of war or any act of war, declared or not.

• Alternative Procedures – Occasionally two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care. In this case, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. This provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. You may choose to apply the alternate benefit amount determined under this provision toward payment of the received treatment.

ELIGIBILITY: The insurance coverage is available in states where it's approved to anyone age 18 and older who does not have coverage through another Ameritas dental plan. You can request coverage for your dependents; dependent eligibility varies based on state law.

DEDUCTIBLE AMOUNT: The deductible is shown in the coverage schedule. The deductible is an amount of covered dental charges incurred by an insured person for which no benefits will be paid.

PREDETERMINATION OF BENEFITS: It is recommended that a treatment plan/course of treatment be submitted when the total cost of eligible expenses for any insured is expected to exceed the amount shown on the coverage schedule. This should be submitted to us before the work is started. If actual services submitted do not agree with the treatment plan, or if a treatment plan is not sent in, we will base our payment on treatment consistent with reasonable and customary charges. Predetermination of benefits is not a guarantee of what we will pay. The estimated benefit payment is based on your current eligibility and benefits in effect at the time of the completed service. Submission of other claims or changes in eligibility or this policy may alter final payment.

TERMINATION OF COVERAGE: Coverage terminates on the earliest of the following dates: the last day of the month in which You cease to be eligible for coverage; the last day of the month in which Your dependent is no longer a

dependent, as defined; subject to the Grace Period, the last day of the month for which a premium has been paid by You or on your behalf; or the date the policy ends.

EFFECTIVE DATE: When you enroll on-line your coverage may start as soon as tomorrow. Do not cancel any other insurance or assume you are insured under this plan until you receive written confirmation. Please note your enrollment may take 2-3 business days to be processed and accessible through any network providers.

ELIGIBLE EXPENSES: Expenses must be incurred while the policy is in force and the person is covered by the policy. To become an eligible expense, the dental services must be performed by: a licensed physician performing dental services within the scope of his license; or a licensed dental hygienist acting under the supervision and direction of a dentist.

MISSING TOOTH: If an insured has lost one or more teeth prior to this policy effective date, we will not pay for a prosthetic device that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted while covered under this policy.U We will pay for fixed bridges or dentures to replace such missing teeth if teeth were extracted within 6 months of this policy effective date if this policy immediately replaces a prior plan.U Replacement of congenitally missing teeth is not covered under your plan unless you are replacing a current fixed bridge or denture. This replacement is subject to contract replacement limits.

Important Fraud Notices

Review your policy carefully

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 below.)

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 policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que fi gura en su tarjeta de identifi cación o al 877-233-2797.

Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

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 D.C. Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 Georgia, Kansas, Nebraska, Oregon, Vermont 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 Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Note for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 New Mexico and Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note for Texas Residents: 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, may be 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 Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

All Spirit Dental & Vision and Direct Vision Insurance plans come with our 30-day Customer Satisfaction Guarantee. You have 30 days after your plan becomes effective to cancel your plan if you are not satisfied for any reason. Any premium paid will be fully refunded provided no covered services have been rendered. If services have been provided, you may still cancel your policy, however, the premium paid will not be eligible for reimbursement. This refund does not include the non-refundable enrollment fee of $25 made at the time of enrollment.

If you voluntarily end your insurance, you will not be eligible to re-enroll for a period of 2 years after the date your coverage first ended.

OUTLINE OF COVERAGE
DENTAL INSURANCE
Ameritas Life Insurance Corp.
PO Box 81889
Lincoln, NE 68501-1889
1-800-487-5533

Outline of Coverage

THIS POLICY PROVIDES DENTAL AND EYE CARE BENEFITS THIS IS NOT A MEDICARE SUPPLEMENT POLICY

1. **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance policy and only the actual policy provisions will control benefit administration. The policy sets forth the definitions of the capitalized terms referred to below.

The policy itself sets forth in detail the rights and obligations of both you and Ameritas Life Insurance Corp. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. **DENTAL AND EYE CARE COVERAGE.** This policy is designed to provide coverage for certain dental and eye care services. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses.

3. **BENEFITS.** We will review benefits subject to the limitations and exclusions described here and more specifically in the policy. When you visit a Participating Provider, a discounted fee is charged for covered services. This is intended to reduce your out-of-pocket costs. The Provider may bill you the difference between the plan payment and the discounted fee amount. If you visit a non-Participating Provider, the Provider may bill you the difference between the plan payment and the dentist's actual charge. Plan payment may be based on usual and customary charges or a set scheduled allowance as described in your policy.

DENTAL

Deductible Amount	
Combined Type 1, Type 2 and Type 3 Procedures – Lifetime	$100
Coinsurance Percentages	
Type 1 Procedures	100%
Type 2 Procedures	
Step 1	50%
Step 2	60%
Step 3	80%
Type 3 Procedures	
Step 1	10%
Step 2	30%

Step 3	50%

Step 1 applies during the first Benefit Period the person becomes insured.
Step 2 will apply during the second Benefit Period.
Step 3 will apply during the third Benefit Period and each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Step 2 as if he or she were newly insured.

For Covered Procedures, we will pay up to the following maximum amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

Maximum Amount -	
1st Benefit Period	$1,200
2nd Benefit Period	$2,500
3rd + Benefit Period	$5,000

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Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	
Step 1.	10%
Step 2.	25%
Step 3.	50%

Step 1 applies during the first Benefit Period the person becomes insured.
Step 2 will apply during the second Benefit Period.
Step 3 will apply during the third Benefit Period and each Benefit Period after.

If, during any Benefit Period, the person has a break in continuous coverage of more than one month, Step 1 will reapply for the balance of that Benefit Period and the person must advance to Step 2 as if he or she were newly insured.

Maximum Benefit During Lifetime	$1,200

If you selected the EyeMed vision plan, the following benefits are included.

EYE CARE

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

When a Participating Provider is used:	
Deductible Amount:	
Exams - Each Benefit Period	$10
Frames	$0

Lenses and Contact Lenses - Each Benefit Period	$20
When a Non-Participating Provider is used:	
Deductible Amount	$0

4. EXCEPTIONS, REDUCTIONS, AND LIMITATIONS OF THE POLICY:

YOUR POLICY CONTAINS A COMPLETE LISTING OF PROCEDURES COVERED AND ANY FREQUENCY OR OTHER LIMITATIONS ON SPECIFIC PROCEDURES.
Certain Covered Expenses may be subject to a Waiting Period (an Elimination Period). Please refer to your policy for details.

Alternate Benefit Provision – At times, two or more procedures are considered adequate and appropriate treatment. In this case, the benefit paid will be based on the charge for the least expensive procedure.

Certain expenses are not covered. For instance, procedures begun prior to your Effective Date are not covered. This policy does not provide benefits for lost or stolen appliances or cosmetic procedures. It also does not cover hospitalization or prescription drugs. This is not a complete list of exclusions. A full list is in your policy.

5. RENEWABILITY. The policy is renewable by payment of the premium in effect at the beginning of each renewal period. Policy termination is governed by the termination provisions in the policy.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF YOUR POLICY. THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

Agent's Name (if applicable):_____
Address:_____
Telephone Number:_____