Fully insured by:

AMERITAS® LIFE INSURANCE CORP.

Administered by:

HealthPlan *Services*

Request for Service

Employee/Dependent Additions/Terminations and Other Changes

Employer's Name _____ Area Code and Phone Number (___) _____

Insured Company's Name _____

Group insurance Case Number _____ Insurance Agent's Name _____

Please check boxes below for desired action and provide requested information, if any.

☐ **Addition of Employee**

Send this form along with completed and signed enrollment card as soon as your new full-time employee is hired. New employees joining a participating firm which also has a medical plan administered by HealthPlan Services will become insured on the same date their medical coverage becomes effective. For new employees of firms without a HealthPlan Services-administered medical plan, dental coverage will become effective on the first day of the month following satisfaction of the waiting period specified on their application (1, 2, or 3 months). This is the employee's eligibility date. All employees must complete an Enrollment Card and the card must be received by HealthPlan Services prior to their eligibility date. If the Enrollment Card is not received by the eligibility date, coverage will become effective on the first day of the month following its receipt by HealthPlan Services. If the Enrollment Card is received by HealthPlan Services more than 31days after the eligibility date the employee is a late applicant. **Only benefits for examinations, cleanings and fluorides will be available during the first year of a late applicant's coverage.**

☐ **Termination of Employee**

Name of Employee _____ Employee # _____ Last Day Worked _____

Name of Employee _____ Employee # _____ Last Day Worked _____

Signature of Company Officer (Mandatory) _____ Date _____

Note: Maximum credit for terminated employees is twelve months, subject to review of claims.

☐ **Addition of Dependent Coverage***

Dependents of employees normally become insured at the same time the employee becomes insured. If an employee wishes to add coverage for a dependent, and the employee's firm has a HealthPlan Services-administered medical plan, dental and medical coverage for the dependent will become effective on the same day. If the employee's firm does not have a HealthPlan Services-administered medical plan, an employee wishing to add dental coverage for a dependent should fill out a Request for Service form. HealthPlan Services must receive this form for newly-acquired dependents (e.g. newborn or through marriage) within 31 days of the dependent's acquisition. If the Request for Service form is not received within 31 days from the date of acquisition, the dependents are late applicants. **Only benefits for examinations, cleanings and fluorides will be available for the first year of a late applicant's coverage.** (Special rules apply for the addition of dependents who have initially waived coverage due to coverage elsewhere. Contact HealthPlan Services for instructions).

Names of *All* Eligible Dependents

Last	First	Relationship	Date Acquired*

Signature of Employee Requesting Change (Mandatory) _____ Date _____

* (1) For an Eligible Spouse - give date of marriage and indicate spouse's date of birth in parentheses. (2) For Adopted Children - give date of legal adoption. (3) For Step - children acquired by marriage - give date of such marriage. (4) For your other children - give their dates of birth.

☐ **Termination of Dependent Coverage** Change will be effective first of the month following HealthPlan Services' receipt of the request.

Signature of Employee Terminating Dependent Coverage (Mandatory) _____ Date _____

☐ **Employee Name Change**

From _____

To _____

Signature of Employee Requesting Name Change (Mandatory) _____ Date _____

MAIL ALL CORRESPONDENCE TO: HealthPlan Services, Inc.
Attn: Case Administration
P.O. Box 30102
Tampa, FL 33630-3102

For additional information, please refer to the Administrative Instructions in your Administrative Kit or call toll free 800/237-1276.

Direct Claims inquiries to toll free 800/487-5553.

Fully insured by:

AMERITAS® LIFE INSURANCE CORP.

Request for Service

Employer/Group Changes

Employer's Name _____ Area Code and Phone Number (___) _____

Insured Company's Name _____

Group Insurance Case Number _____ Insurance Agent's Name _____

Please check boxes below for desired action and provide requested information, if any.

☐ **Change/Correct Mailing Address To:**

_____
number street suite

_____
city state zip code

_____
telephone number

Address change may affect your area rating. Changes will be effective the first of the month following receipt of the request.

☐ **Supply Request**

☐ Enrollment Cards _____
☐ Request for Service Forms _____
Claim Forms
☐ Dental _____

Indicate amount needed

Send To: Insured Company Name _____

Address _____

City/State _____ Zip _____

☐ **Other**

Signature of Company Officer _____ Date _____
(Mandatory for processing any request)

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