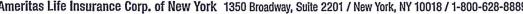
enrollment/change/waiver Group Insurance Form Ameritas Life Insurance Corp. of New York 1350 Broadway, Suite 2201 / New York, NY 10018 / 1-800-628-8889





Policy and Div. # 026-201507 Cert. #	ř.	is	a co	A: If individual ntinuee:	Section.	- "			Date of Event	Tal
Name and Address of Employer (Policyholder) Canastota	CS	D	120	Roberts	St Car	nast	tota NY 1	.3032	typuda ikus	1115
to enroll □ Dental □ Eye Care □ To te Employee Information Marital Status □ Single □ Married □ Civil Union* □ Don Social Security number □ □	erm mes Dept	ina tic F	te a Parti	all coverage ner* *As defined er	S by state la	w or y	our Group.			
Employee's last name, first name, MI Date of birth		(6)			The self is		Super Street, Ty	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
Date of birth	Full	tim	e da	te of hire	144		_ Rehire	Rehire da	te	
Occupation		_ Ho	ours	worked each	week	_ A	re your earni	ngs paid:	☐ Hourly or ☐] Salaried
Street address				City				_ State	ZIP	*
E-mail address (limit of 60 characters)								1.	11 4 1 1 1 1 1 1	
Are you covered under another dental insurance plan? Are you covered under another eye care insurance plan?		٠.			.Employ	ee:	☐ Yes ☐ N	o Depe	endents: Ye endents: Ye	es 🗆 No es 🗆 No
Dependent Coverage Information List all eligible depend					d. (Employ	yee m	oust be enrolle	d to cover d	lependents)	name of
Print full legal name (last, first. MI) Dental add (dro					hin	Sex	Date of bir	th Soc	cial Security no.	College student?
][[_		- Holdstone	, mp	- COM			100	
		_		- n 1 2 o	Janes .		by the	+110.5	- 1,5 T	
<u> </u>					25 110	1-	A SP AP S		10	
intr	10	_								
4	11	7	一							1.0
I have read and understand. I represent that the information certifies the date of employment, job title, hours worked and X Employee Signature (do not print) Date Any person who knowingly and with intent to defraud any incontaining any materially false information, or conceals for	sala sura the	ary ince	co cos	mation are cor X Policyholdempany or other e of misleading	er Signatur r reason i	e (do liles a	to the Policyl not print) an application concerning a	nolder's rec	Date nce or statemer	at of claim
fraudulent insurance act, which is a crime, and shall also be claim for each such violation.	sul	bjec	t to	a civil penalty	not to ex	ceed	five-thousan	d dollars ar	nd the stated va	lue of the
Employee late entrant date Ef	ffecti	ve D	ate		Class		Dep. Code	1		
Dependent late entrant date		9]		
to change □ Name Change New Name □ Add Dependent Coverage □ If due to marriage, what is the date of marriage? □ If due to loss of coverage, date and reason:				☐ If due to b	irth/adopt	ion, v	vhat is the dat	e of event?_		
☐ If other, the date of event and please explain:										
☐ Drop Dependent Coverage Number of dependent ☐ Due to divorce ☐ Due to death ☐ Due to annu ☐ Other (please explain)	ıal e	lect	ion	period 🗌 Ex	ceeds m	aximı	um age to qua	lify as dep	endent	
to waive If you do not want coverage, complete EMPLOYER. I have been given an opportunity to apply for Group myself (does not apply to TRUST policies) spouse/do	mes	tic	pari	iner 🗌 child	(ren) only] spouse/don	nestic parti	ner and child(re	H YOUR n)
because										
Name of insurance company and employer of dependent Should I desire to apply for this group insurance in the future	, I re	ealiz	e th	nat a "late entra	ant" pena	Ity m	ay be applied	•		