

Ameritas **First** Dental, Vision, LASIK and Hearing Options
through 12/31/2024

NEVADA GROUP PLAN SELECTION FORM

COMPLETED FORM MUST BE ATTACHED TO THE AMERITAS GROUP APPLICATION

Date Completed:		Requested Effective Date:	
Group Name:		Broker Name:	
Group State and Zip Code:		Broker State and Zip Code:	
# of Eligible Employees:		Broker Phone #:	

☐ **DENTAL** (May be offered stand-alone or with Vision and/or LASIK & Hearing add-on)

1) **Select ONE Ameritas **First** Dental PPO Plan & Ortho Option (if desired):**

- Ameritas **First** PPO Dental Rates are 4-Tier
- Requires minimum 2 enrolled (participation requirements below)
- Ortho Option minimum 3 or more enrolled with children/family dependent units in the Ameritas **First** PPO Plan

DENTAL PPO PLAN:	OPTIONAL ORTHO:
<input type="checkbox"/> 1100 Plan	N/A
<input type="checkbox"/> 1600 Plan	<input type="checkbox"/> Add Ortho
<input type="checkbox"/> 1600 Incentive Plan	<input type="checkbox"/> Add Ortho
<input type="checkbox"/> 2100 Plan	<input type="checkbox"/> Add Ortho

2) **Select ONE Ameritas **First** Dental PPO Rate Segment:**

- Select one Dental Rate Segment –
 - This is determined by the total # of eligible employees

DENTAL PPO RATE SEGMENT:
<input type="checkbox"/> 2– 9 PPO eligible
<input type="checkbox"/> 10 – 50 PPO eligible
<input type="checkbox"/> 51 – 199 PPO eligible

3) **Select ONE Ameritas **First** Dental PPO Contribution/Participation Option:**

<input type="checkbox"/> Voluntary: Minimum 2 Enrolled PPO Lives, NO Participation % Required (Dual Choice allowed for CA sitused groups)
<input type="checkbox"/> Employer Sponsored – Straight PPO: Minimum 50% Employer Contribution / Minimum 50% participation or two (2) Enrolled PPO Lives, whichever is greater
<input type="checkbox"/> Employer Sponsored – Dual Choice: Minimum 50% Employer Contribution of PPO or DHMO / Minimum 75% combined (PPO & DHMO) participation with a minimum of 2 enrolled PPO lives. (Enrollment Breakdown: PPO _____ / DHMO _____)

4) **Select ONE Ameritas **First** Dental PPO Waiting Period for Major & Ortho Option:**

<input type="checkbox"/> Include the 12 month waiting period for Dental and Ortho (no prior coverage)
<input type="checkbox"/> Takeover Group - Waiting Period Waived - Group has existing dental PPO/DHMO/EPO coverage that has been in force for 12 or more months (attach proof of prior coverage)
<input type="checkbox"/> Virgin and Non-Takeover Group – 1.150% Rate Factor (+15.0%) to Waive Waiting Periods on Major and Ortho Coverages for Existing Employees and New Hires

Group Name:

☐ **VISION** (May be offered stand-alone or with Dental and/or LASIK & Hearing add-on)

Select ONE Ameritas First Vision Plan:

- Select **ONE** Plan and Benefit Frequency (Check one box)
- NV Sitused Groups
- Requires minimum of 2 enrolled lives
- **Ameritas First** Vision Rates are 4-Tier

PLAN NAME:	Benefit Frequency: Exam-Lenses-Frames	
	12-12-12	12-12-24
VSP Focus Plan 1	<input type="checkbox"/>	<input type="checkbox"/>
VSP Focus Plan 2	<input type="checkbox"/>	<input type="checkbox"/>
VSP Focus Plan 3	<input type="checkbox"/>	<input type="checkbox"/>
EYEMED ViewPoint Plan 1	<input type="checkbox"/>	<input type="checkbox"/>
EYEMED ViewPoint Plan 2	<input type="checkbox"/>	<input type="checkbox"/>
EYEMED ViewPoint Plan 3	<input type="checkbox"/>	<input type="checkbox"/>
Vision Perfect MCE Plan	<input type="checkbox"/>	N/A
Vision Perfect Flat Max Plan \$150	N/A	<input type="checkbox"/>

☐ **LASIK & HEARING Add-on** (May be offered with Dental and/or Vision)

Select ONE Ameritas First LASIK & Hearing Plan:

- Select Plan 1 or Plan 2 (Check one box)
- **Ameritas First** LASIK & Hearing Rates are 4-Tier
- **THIS IS AN EMPLOYER PAID OPTION FOR EVERYONE COVERED ON AMERITAS DENTAL OR VISION**
- Minimum of 10 or more enrolled lives in an eligible **Ameritas First Dental or Vision Plan**
- **In NO event can a person be covered for Ameritas Simple Add-Ons LASIK & Hearing and not be covered on the Group Dental or Vision plan**
- Refer to the **Ameritas** LASIK and Hearing Care Coverage document on the Word & Brown Forms page for covered services, exclusions and limitations.

LASIK & HEARING PLAN SELECTION:	PLAN 1	PLAN 2
	<input type="checkbox"/>	<input type="checkbox"/>
LASIK Lifetime Benefit (per Eye)	\$175 year 1 \$175 year 2 \$350 year 3	\$350 year 1 \$350 year 2 \$700 year 3
Annual Hearing Exam Benefit	\$75	\$75
Hearing Aid Benefit (per Ear)	\$100 year 1 \$300 year 2 \$400 year 3	\$400 year 1 \$600 year 2 \$800 year 3
Hearing Aid Maintenance	\$40	\$40