AMERILIFE® BENEFITS | Taylor & Sons Insurance Services

June 1, 2023

Retiree
Red River Parish School Board

Re: Dental & Vision Carrier Change, Effective 7/1/2023

Dear Retiree:

Thank you for your continued business with AmeriLife Benefits/Taylor & Sons Insurance Services. The purpose of this letter is to inform Red River Parish School Board retirees of the dental and vision carrier change, effective 7/1/2023.
Your current coverage with Bright Benefits Dental and/or Vision will terminate 6/30/2023.
Retirees may continue Dental and/or Vision coverage by completing an Ameritas Enrollment form and Bank Draft Authorization. These forms are enclosed.

The AmeriLife Benefits Customer Support Team is available to assist with any questions and/or concerns you may have regarding this change.
Completed forms along with a voided check may be mailed, emailed, or faxed to:
Mail: AmeriLife Benefits/Taylor & Sons Insurance Services
1201 Derek Drive, Suite A
Hammond, LA 70403
Email: CustomerSupport@AmerilifeBenefits.com
Fax: 1-844-665-7638

Should you have any questions regarding the enclosed, or if our office can be of any further assistance to you, please do not hesitate to contact us.
AmeriLife Benefits/Taylor & Sons Insurance Services
Phone: 833-909-1578
Email: CustomerSupport@AmerilifeBenefits.com

Sincerely,

AMERILIFE® BENEFITS | Taylor & Sons Insurance Services

CLEAR FORM

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Ameritas

A **Red River PSB 010-62038**
Effective Date: 07/01/2023

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

1 to enroll ☐ Dental ☐ Eye Care ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth _____ ☐ Male ☐ Female Full time date of hire **N/A** ☐ Rehire: Rehire date **N/A**

Occupation **RETIREE** Hours worked each week _____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address _____ City _____ State _____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . . **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No
Are you covered under another **eye care** insurance plan? . . . . . **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental add	Dental drop	Eye Care add	Eye Care drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐	☐	☐					☐
2	☐	☐	☐	☐					☐
3	☐	☐	☐	☐					☐
4	☐	☐	☐	☐					☐
5	☐	☐	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), 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. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ X _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

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 on back.)

Employee late entrant date _____
Dependent late entrant date _____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name _____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage? _____ ☐ If due to birth/adoption, what is the date of event? _____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain: _____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop: _____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

EFT Form

Electronic Funds Transfer Authorization

Ameritas Life Insurance Corp. P.O. Box 82669 / Lincoln, NE 68501 / 800-659-2223 / Fax: 402-467-7338

Request and Authorization for Bank Payment Plan

It's the simplest method of paying your premium. No more checks to write! It's automatic and reliable. We call it electronic funds transfer (EFT for short). It allows for peace of mind however you do business — whether it's online or through the mail.

Online: Groups that receive invoices online, you have the freedom to choose when we debit your account. When you're ready, just visit our website, ameritas.com, sign into your secure account and click PAY BILL. We'll draft your premium payment right away.

Mail: Groups that receive their invoices through the mail, just authorize us to debit your account each month and we'll do the rest. It's the forget-proof method of paying your premium.

Authorized Agreement for Prearranged Payments (Debits)

Group Policy # 010-62038 Phone # _____

Policyholder Name RED RIVER PARISH SCHOOL BOARD

Policyholder Contact RETIREE NAME:

☒ New Authorization ☐ Change of Account

☐ Checking Account ☐ Savings Account

I hereby authorize Ameritas to initiate debit entries to the account number listed below, and at the bank named below, herein called BANK, to debit the same to such account. The EFT draft will be monthly or quarterly, whichever payment option was selected, on or about the first day of the coverage period.

Bank Account Number _____ Bank Routing Number (9 digits) _____

Bank Name _____

Account Name _____

Address _____

City _____ State _____ ZIP _____

Phone Number of Financial Institution _____

To ensure a timely and effective setup, it is necessary to send a voided check with this request.

This authorization is to remain in full force and in effect until BANK has received written notification of its termination in such time and such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first.

	RETIREE
Name (print)	Title of Authorized Signer
X	
Signature	Date
	N/A
	Federal Tax ID#

Please keep a copy of this form for your records.