It's smart to put your money where your mouth is.

Ameritas BrightOne Plans are available only to members of the Plan Services Association.

WHAT KINDS OF SERVICES ARE COVERED?

1. TYPE 1 CARE
   - Oral Exams
   - Prophylaxis (cleanings)
   - Fluoride treatments (for children under 19)

2. TYPE 2 CARE
   - X-rays: full-mouth series, bitewings, occlusal, panoramic
   - Amalgams (fillings), space maintainers
   - Simple extractions

3. TYPE 3 CARE
   - Endodontics (root canals)
   - Periodontics (gum disease)
   - Crowns, bridges, onlays, pontics, general anesthesia (if medically necessary)
   - Sealants

WHAT ALLOWANCES IMPACT MY PLAN?

WISE BUYER (Traditional, Advantage I and Advantage II Plans)
Reimbursements are based on the median dental fees charged per procedure in the specific ZIP Code area where dental services were performed.

USUAL AND CUSTOMARY (U&C) (Progressive Plan)
- Benefits for a given dental procedure are paid according to the usual and customary charge for that procedure within a particular geographic market.
- The U&C benefits are calculated as 90% of the usual and customary fees for a procedure, which means that 9 out of 10 dentists in a specific area charge at or below the plan allowance for a procedure.

For more information visit us at www.healthplan.com

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According to the American Dental Hygienists' Association, every $1 spent on prevention in oral health care saves $8 to $50 on restorative and emergency procedures. That's one reason why BrightOne Plans pay 100% on preventive dental procedures, such as cleanings and exams, whether the patient is covered under the Traditional, Progressive, or Group Plans. And for families and individuals, BlindOne Plans pay 60% to 80% on preventive care after a short elimination period.

Covering a family in one plan, or an individual in two plans, can be more affordable and convenient. It's a single-minded focus: WELL-BEING.

TRADITIONAL PLAN

WELL-BEING...on your HEALTH and

A single-minded focus:
I hereby apply for full associate membership in the Plan Services Association (PSA). Upon completion of this enrollment form and payment of initial dues (3 months), I understand that: (a) I will be entitled to PSA’s benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this Enrollment Form is dated and signed; (d) I am eligible to apply for Association Group dental insurance; and (e) I authorize the release of my name and address listed on this application to PSA.

if you wish to apply for association group dental insurance, please complete the enrollment form below.

AMERITAS BRIGHTONE® PLANS ENROLLMENT FORM

SECTION ONE — APPLICANT INFORMATION

Required Member’s Signature Title Date

Name of Primary Applicant (Last, First, MI)

Marital Status Social Security Number DOB Gender

Primary Applicants Address (P.O. Boxes Are Not Accepted) City State Zip

Phone Numbers Home Work E-Mail Address

Billing Address (If Different From Above) City State Zip

Coverage Dependent: (Check One) □ Applicant Only □ Applicant Plus One Dependent □ Spouse or □ Child □ Applicant Plus Two or More Dependents □ Spouse and/or □ Children How Many...

SECTION TWO — COVERAGE INFORMATION

Requested Effective Date: Month Year

(Note: Plan Effective Date Is Always First Of The Month And Subject To Written Approval)

Select plan design (Choose One Of The Four Plans): □ Traditional □ Progressive □ 75% Annual Maximum □ 100% Annual Maximum

SECTION THREE — BILLING INFORMATION

Payment Method (Producer Payments Are Not Accepted)

□ Monthly EZ Pay One month premium required (no charge)

□ Monthly Direct Billing Option One month premium required (38 monthly administration fee)

□ Quarterly Direct Billing Option Three months premium required (38 quarterly administration fee)

EZ Pay Agreement

□ Yes □ No

Primary Payor’s Signature Date

Name Of Financial Institution

Checking / Savings Account Number

Financial Institution Address City State Zip

Specify Type Of Account □ Checking □ Savings

ABA 9 Digit Routing Number (See Below Or Please Call Your Financial Institution For Assistance)

Ameritas and/or HealthPlan Services, acting as Plan Administrator on behalf of Ameritas, is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Certificate is not issued. If I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by HealthPlan Services, and I agree that the bank named shall be fully protected in honoring any such payments. The bank’s rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Ameritas and/or HealthPlan Services in writing.

Section Four — Contract Please Sign

In several states, we are required to advise you of the following: 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 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 group policies issued, amended, delivered or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.]

[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 New Jersey Residents: Any person who includes any false or misleading information on an application or statement of claim containing any materially false information or conceal any fact material thereto commits a fraudulent insurance act, which is a crime and subject to criminal and civil penalties.]

As a member, I hereby apply for insurance. These benefits were 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.

Section Five — Producer Information

Name

Social Security Number

License Number

Agency Name (If Applicable)

E-Mail Address

Phone Numbers Home Work Fax

Address

City State Zip

Are you licensed / appointed with Ameritas Life Insurance Corp.? □ Yes □ No

Service Fees Payable To (Check One) □ Individual □ Firm □ Other, Please Specify

Producer’s Signature Date