

SERFF Tracking Number: AMFA-127851001 State: Arkansas
Filing Company: Ameritas Life Insurance Corp. State Tracking Number: 50354
Company Tracking Number: 11264 7176 GEN 11/11
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: 11264 7176 GEN 11/11
Project Name/Number: 11264 7176 GEN 11/11/11264 7176 GEN 11/11

Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: 11264 7176 GEN 11/11

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: AMFA-127851001 State: Arkansas

SERFF Status: Closed-Approved State Tr Num: 50354

Co Tr Num: 11264 7176 GEN 11/11 State Status: Approved-Closed

Reviewer(s): Donna Lambert

Author: Janis Landon

Disposition Date: 12/01/2011

Date Submitted: 11/29/2011

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 01/02/2012

State Filing Description:

General Information

Project Name: 11264 7176 GEN 11/11

Project Number: 11264 7176 GEN 11/11

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Trust

Filing Status Changed: 12/01/2011

State Status Changed: 12/01/2011

Created By: Janis Landon

Corresponding Filing Tracking Number:

Filing Description:

RE: AMERITAS LIFE INSURANCE CORP.

NAIC NO: 943-61301

FEIN NO: 47-0098400

Group Dental & Eye Care Application

Form: 11264 7176 GEN 11/11

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Janis Landon

Dear Sir/Madam:

Enclosed for your review and approval is the above application form. This form will be used with trust certificate 9021 Trust Rev. 03-08 approved by your Department on_____.

<i>SERFF Tracking Number:</i>	<i>AMFA-127851001</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Ameritas Life Insurance Corp.</i>	<i>State Tracking Number:</i>	<i>50354</i>
<i>Company Tracking Number:</i>	<i>11264 7176 GEN 11/11</i>		
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This employer's application will be used to subscribe to the Midwestern Employers Trust for the Settlor, Health Plan Services, Inc. and to elect plan options. The trust was formed for the purpose of implementing group insurance plans for the benefit of employees of employers in various industries as defined by the trust agreement. This form will replace 11264 6048 GEN 07/08.

If you should have any questions, please don't hesitate to contact me at 800-745-1112, Ext. 82444, FAX 402-309-2573 or email jlandon@ameritas.com.

Sincerely,
 Janis Landon
 Senior Contract Analyst
 Ameritas Life Insurance Corp.

Company and Contact

Filing Contact Information

Janis Landon, Senior Contract Analyst	jlandon@ameritas.com
475 Fallbrook Blvd.	800-745-1112 [Phone] 82444 [Ext]
Lincoln, NE 68521	402-309-2573 [FAX]

Filing Company Information

Ameritas Life Insurance Corp.	CoCode: 61301	State of Domicile: Nebraska
5900 O Street	Group Code: 943	Company Type:
P O Box 81889	Group Name:	State ID Number:
Lincoln, NE 68501-1889	FEIN Number: 47-0098400	
(800) 756-1112 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	\$50.00	11/29/2011	54105160

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/01/2011	12/01/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	11/30/2011	11/30/2011	Janis Landon	12/01/2011	12/01/2011

SERFF Tracking Number: AMFA-127851001 *State:* Arkansas
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Disposition

Disposition Date: 12/01/2011

Implementation Date: 01/02/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Form	Application	Approved	Yes

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/30/2011
Submitted Date	11/30/2011
Respond By Date	12/30/2011

Dear Janis Landon,

This will acknowledge receipt of the captioned filing. Please provide a copy of the trust agreement or the SERFF or STATE tracking # of the pervious approval. (The date of approval of the trust certificate was left blank in the filing description.)

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 12/01/2011
Submitted Date 12/01/2011

Dear Donna Lambert,

Comments:

Response 1

Comments: My apologies for this oversight. The trust certificate was approved under SERFF # AMFA-125577585 on 3/31/08. The trust policy is situated in Minnesota.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Janis Landon

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Form Schedule

Lead Form Number: 11264 7176 GEN 11/11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/01/2011	11264 7176 GEN 11/11	Application/ Enrollment Form	Application	Revised	Replaced Form #: 11264 6048 GEN 07/08 Previous Filing #: AMFA-125769109	50.000	7562 AMPearlApp Gen_WR_2.p df

SECTION 2: COVERAGE INFORMATION

Requested effective date: Month _____ Day _____ Year _____

Effective Date Agreement

In the event of a delay of approval, I request:

If no prior coverage

- Original requested date
 Date HealthPlan Services Underwriting approves application

If prior coverage in force

- Original requested date
 A later date coinciding with termination of prior carrier

If not completed, the original requested effective date option is automatically selected. The option selected cannot be changed. Later effective dates are subject to any appropriate new business plan and rate changes made by the Trust. Subject to written approval of the employer's participation by the Trust Administrator, insurance will be effective as of the requested date. Employees hired after the effective date of insurance will be insured in accordance with Section 2 of this Employer's Request.

Service Waiting Period before employee becomes eligible:
(If Dental is written in conjunction with a HealthPlan Services Medical plan, the Medical plan's service waiting period will apply.)

- 1) For employees at work on the effective date: None
2) For employees hired after the effective date:

Check one: 0 30 60 90 days

The eligibility date is the first of the month following completion of the service waiting period.

Employees have 31 days from their eligibility date to sign and forward an enrollment card. If an employee does not enroll within 31 days of the date he or she becomes eligible, his or her maximum benefit, and the maximum benefit for his or her insured dependents, will be limited. Refer to your policy for details.

Premiums, including an initial deposit equal to the first full month's premium, are payable monthly in advance. The employer contribution must be at least 25% of the total cost of Dental Insurance, or the full cost of the employee coverage.

SECTION 3: EMPLOYEE INFORMATION

Total number of employees (including active Partners, Proprietors, and Corporate Officers) _____

Number of eligible employees _____

Number of ineligible employees _____

Part-time _____ Seasonal _____ Other _____

Total number of employees enrolling:

- Employee Only _____
 Employee plus one Dependent _____
 Employee plus two or more Dependents _____

I understand that participation requirements must be met at all times. Yes

SECTION 4

This Employer's Request is a Counterpart to an Indenture of Trust. The Trustee and Insurance Policyholder is U.S. Bank National Association. The Trust Administrator is HealthPlan Services, Inc. The Insurer is Ameritas Life Insurance Corp. I, the undersigned employer, wish to become a participating employer in the HealthPlan Services Trust applicable to my industry classification, pursuant to Article IV, Section 1 of the Trust Indenture, and to apply for insurance coverage under the Master Policy(ies) issued to the Trustee. I am acquainted with the rules of eligibility and understand that the effective date of the insurance for which I am applying shall be subject to the written approval of the Trust Administrator, acting on behalf of the Insurer. I understand that the benefits provided shall be subject to the terms of the group insurance policy(ies) issued to the Trustee, as amended from time to time, and that these group insurance policies may be terminated by the Insurer following due notice to the

Trustee. I agree to remit to the Trustee regularly in advance the required monthly premium contributions for insurance benefits, and I understand that failure to pay billed premiums will result in automatic termination of insurance coverage. I agree to offer the insurance to all present and future new employees who work for remuneration on a full-time basis. I also agree to maintain the participation requirements of the plan with respect to eligible employees and their eligible dependents in order to procure and continue the requested insurance and agree that any insurance issued as a result of this request may be cancelled as of any monthly premium due date if such participation requirements are not maintained. I hereby represent that I have read and understand the Insurance Plan, including all exclusions and limitations of coverage.

AGREEMENTS

The Applicant understands that he/she, and not HealthPlan Services, Ameritas nor the Trustees, is the Plan Administrator and Fiduciary as defined in the Employee Retirement Income Security Act of 1974, as amended.

The Applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. All statements and descriptions are deemed to be representations and not warranties.

If this application is accepted by Ameritas, group insurance at the current Company's rates and under the terms applied for shall take effect as of the date shown in section 1 of this Employer's Request. If this application is not accepted, any premium advanced shall be refunded. Ameritas reserves the right to reject any case which, in its opinion, does not conform to sound underwriting criteria. No insurance is in force until written acceptance is received.

STATEMENTS

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 (see state specific statements).

The policy provides dental and eye care benefits only. Review your policy carefully.

Signed at (City) _____ (State) _____ on (Month) _____ (Day) _____ (Year) _____

Dated at (City) _____ (State) _____ on (Month) _____ (Day) _____ (Year) _____

Employer's Legal Business Name _____

Employer's Signature _____ **Title** _____

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 Washington, D.C. Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Florida Residents: 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 Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Note for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico and Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

Note for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note for Texas Residents: 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, may be 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.

A signed copy of this form received by electronic transmission will be deemed to be an original.

PLEASE PRINT

Writing Agent/Broker:

Name _____ Check one: Social Security # Tax ID # _____

Phone number () _____ Fax number (include area code) _____

Email address _____ (Important: may assist in case issue)

Service Fees Payable to:

Name _____ Check one: Social Security # Tax ID # _____

Address _____
City State Zip Code

Phone number (include area code) _____

General Agent's Fax Number (include area code) _____
(Important: may assist in case issue)

Copy of my Ameritas Life Insurance Corp. license

Not licensed with Ameritas

FOR GENERAL AGENT'S USE

Agent's/Broker's Statement:

To the best of my knowledge all statements in the Employer's Request for Group Insurance and Group Insurance Enrollment Cards are complete and true. I represent the applicant for the insurance, not the Insurance Company.

If I am not already appointed with Ameritas Life Insurance Corp. I understand and agree that before I present this product to any client, I must apply to and be appointed with Ameritas. My client has been advised by me not to terminate any existing coverage until receiving notice that the coverage being applied for is accepted. I agree that I have no right to bind this coverage, alter terms of the Insurance Contract or Employer's Request for Group Insurance, or adjust any claim for benefits under the insurance contract.

Agent's/Broker's Signature _____ Date _____

Agent's/Broker's Name (Print) _____ License Number _____

<i>SERFF Tracking Number:</i>	<i>AMFA-127851001</i>	<i>State:</i>	<i>Arkansas</i>
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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	12/01/2011
Comments:			
Attachment:			
AR - readability-alic.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	12/01/2011
Bypass Reason:	located under form tab		
Comments:			

STATE OF ARKANSAS
CERTIFICATE OF READABILITY

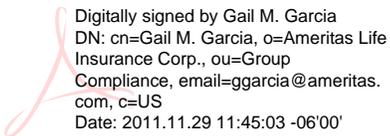
INSURER: Ameritas Life Insurance Corp.

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

<u>FORM NO:</u>	<u>FLESCH SCORE:</u>	<u>FORM NAME:</u>
11264 7176 GEN 11/11	50, with policy/certificate	insurance application and subscription to the trust
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: **Gail M. Garcia**
TYPED NAME: Gail M. Garcia
TITLE: Vice President - Group Compliance
DATE: 11/29/2011



Digitally signed by Gail M. Garcia
DN: cn=Gail M. Garcia, o=Ameritas Life Insurance Corp., ou=Group Compliance, email=ggarcia@ameritas.com, c=US
Date: 2011.11.29 11:45:03 -06'00'