provider nomination form

To have information sent to your dentist about joining the Ameritas/ Ameritas of New York Network, please complete and fax this TOLL FREE to 866-494-2585.

☐ **YES!** I'd like my dentist to know more about the Ameritas Network. Please send information to: (please print clearly)

Dentist Name____

Address____

City/State/Zip____

Phone Number____

Employer Name____

☐ I allow Ameritas permission to use my name in their network recruitment efforts.

Print Name____

Signature____

Please tell your dentist you requested an application packet be mailed to his/her office. Thank you!

Ameritas Life Insurance Corp.
Ameritas Life Insurance Corp. of New York