

NEW BENEFITS FOR AMA MEMBERS



VISION BENEFITS

Services Offered - All services are offered once in a 12 month period

Lifetime-Per Person Deductible of \$65.00 on Frames and Contact Lenses ONLY!

Service	Maximum Covered Expense
Examination —Includes case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance; tonometry test for glaucoma; gross visual field when indicated; summary finding; prescribing of lenses	\$45.00
Frames	\$65.00
Lenses (Per pair of lens-Patient pays remainder)	
Single	\$40.00
Bifocal	\$60.00
Trifocal	\$75.00
No line bifocal or progressive power OR Lenticular	\$80.00
Contact Lenses	\$110.00

Over 400 Covered Dental & Vision Procedures

- Choice of Four Dental Plans and One Vision Plan to Meet Your Needs
- You Can Use Any Licensed Dentist or Vision Care Provider
- Easy Premium Payment Methods
- You Can Not Be Turned Down

VISION PREMIUMS

Monthly Rates

Single Only	\$5.88
Insured & 1 (child or spouse) ...	\$10.96
Insured & 2 or more	\$15.96

*Please refer to your certificate of insurance for complete details on all benefits, frequencies and plan limitations.

*Eligible applicants for both the dental and vision programs must be a member in good standing of the Consolidated Association of Resolute Employers (CARE).

See Reverse Side for Dental Benefit Information

For More Information Call 800-747-4472



Ameritas Dental & Vision Plan Enrollment Form

To enroll, complete the following form and mail along with your payment to: Central Billing Service, PO Box 8633, Madison WI, 53708-8633

Name: _____
(FIRST) (M.I.) (LAST)

Affiliation (If Applicable) AMA

Home Address: _____
(CITY) (ST) (ZIP)

*Social Security # _____
*Social Security Number is Needed for your Policy Number

Phone _____ Birthday (mm/dd/yyyy): _____

Requested Effective Date: _____

Plan(s) Enrolling In (check one or both):

- Dental Vision

Coverage Enrolling In (check one):

- Single Insured & Spouse Insured & Child(ren) Family

Do you have any eligible dependents, including a spouse?

- Yes No If yes, provide the following information to enroll

them. **(Name, Gender (M/F), Birthday)** *(Attach Additional Sheets if Necessary)*

Monthly Dental Premium	\$ _____
Monthly Vision Premium	\$ _____
CARE Membership Fee	\$1.00/Month
Total Due Per Month.....=	\$ _____

I hereby enroll in the Ameritas Life Insurance Corp. Dental Plan and understand that I am also enrolling in the CARE Association.

 Enrollee's Signature / /
 Date

 Agent Signature (If Applicable)

See Reverse Side For Payment Options

DENTAL BENEFITS

Benefit Outline—Over 400 Covered Procedures

Deductible—\$50 Calendar Year-Per Person Deductible for Basic and Major Services ONLY!

Elimination Period—12 Month Waiting Period on Major Procedures

<i>Sample Schedule of Benefits - How much the insurance will pay</i>	CLASS 1	CLASS 2-4
Plan Maximum Per Calendar Year-Per Person	\$1,000	\$1,000
Preventive * - NO DEDUCTIBLE		
Two evaluations per calendar year	100%	100%
Two cleanings per calendar year	100%	100%
Fluoride for Children (Under age 19)	100%	100%
Space Maintainers	100%	100%
Radiographs (X-rays)	100%	100%
Bitewings (Allowed twice per calendar year)	100%	100%
Basic		
Sealant-per tooth (Coverage is limited to treatment of the occlusal surface of permanent molar teeth once during a 3-year period) (Age 16 and under)	\$18	\$21
Amalgam restoration (silver fillings)—one surface, primary or permanent	\$41	\$48
Extraction—Erupted tooth or exposed root (elevation and/or forceps removal)	\$46	\$54
Surgical removal of tooth (completely bony)	\$171	\$200
Denture repair—Repair Broken Base	\$52	\$61
Deep sedation/general anesthesia	\$131	\$154
Major		
Maxillary partial denture—resin base	\$135	\$166
Endodontics—root canal, anterior	\$105	\$129
Periodontal scaling and root planning, limited (per quadrant). Each quadrant is eligible	\$35	\$43
Crown—full cast noble metal	\$152	\$187
Crown repair	\$29	\$36
Pontics—porcelain fused to noble metal	\$156	\$192

* Preventive benefits are paid at 100% of the average charge in your zip code area

DENTAL PREMIUMS BY STATE

Monthly Rates for Class 1

AL, AR, IA, IN, KS, KY, LA, MO, MS, ND, NE, NM, OH, OK, SC, SD, TN, TX, WV

Single Only	\$20.40
Insured & Spouse.....	\$40.24
Insured & Children	\$52.44
Family	\$72.28

Monthly Rates for Class 2

AZ, CO, DE, FL, GA, ID, IL, MD, ME, MI, MN, MT, NC, NH, NV, OR, PA, RI, UT, VA, VT, WI, WY

Single Only	\$26.96
Insured & Spouse	\$53.32
Insured & Children	\$63.36
Family	\$89.72

Monthly Rates for Class 3

AK, CA, CT, DC, HI, MA, NJ, NY, WA

Single Only	\$36.96
Insured & Spouse	\$72.92
Insured & Children	\$83.20
Family	\$119.16

Monthly Rates for Class 4

NY & CA ZIP CODES: 100XX, 101XX, 102XX, 950XX, 951XX

Single Only	\$41.40
Insured & Spouse	\$81.68
Insured & Children	\$93.20
Family	\$133.48

*Please refer to your certificate of insurance for complete details on all benefits, frequencies and plan limitations.

Please Select and Check One of the Following Payment Methods

VISA Monthly **MasterCard Monthly**

Please submit one month's premium made payable to GIS

Name as it appears on the card: _____

Account# _____ - _____ - _____ - _____

Expiration Date: ____/____/____

Cardholders Signature: _____

Personal Account Insurance Deduction (P.A.I.D.)

(Arranged by Greater Insurance Service Corp)

Please Complete all information to the right for P.A.I.D.s

Instructions for P.A.I.D.:

1.-Please submit one month's premium made payable to GIS & voided check (no deposit slips).

2.-Premiums will be deducted the 10th of each month for the following month's premium.

GIS ONLY:

TRANSMIT/ROUTING ABA# _____

ACCT. NO. _____

Payor Name _____

Address _____
(include address, city, state and zip)

WITHDRAWAL AUTHORIZATION Checking Savings

Name of Depositor _____

(Print name as shown on Financial Institution Records)

To Financial Institution _____

(Address of Institution or Branch where account is maintained)

As a convenience to me, I hereby request and authorize you to pay and charge to my account maintained at the above named financial institution for the payment of premiums owed on policies I currently have or may purchase and desire to include under the P.A.I.D. and Credit Card Account Agreement. Amounts drawn on my account will be payable to the order of Greater Insurance Service Corp. provided there are sufficient funds in said account to pay the same upon presentation. I agree that you shall be duly protected in honoring any such charge. This authorization is to remain in effect until revoked by us in writing and, until Greater Insurance Service Corp. receives such written notice of revocation I agree that Greater Insurance Service Corp. shall be fully protected in drawing such amounts. Greater Insurance Service Corp. assumes no responsibility for a policy lapse or cancellation due to non-payment. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of my rights in respect to each such charge shall be the same as if they were signed personally by me. A customer has the right to stop payment of a debit entry by notification to Financial Institution prior to charging account. After account has been charged the customer has the right to have the amount of an erroneous entry immediately credited to their account by Financial Institution up to 15 days following the issuance of statement or 45 days after posting, whichever occurs first.

_____ Date

_____ Signature of Depositor