Ameritas Dental/Vision Plan Application

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

Each Enrolling Employee Must Fill Out a Separate Form

Dental/Vision Plan Enrollment Form

(Please Print Clearly)

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

Address: _____

_____
(CITY) (ST) (ZIP)

Business Name: _____

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

Birthday (mm/dd/yyyy): _____

Phone: _____

Requested Effective Date: _____

Plan Applying For

☐ State 100

Coverage Applying For (check one):

☐ Single Only ☐ Insured & Spouse
☐ Insured & Child(ren) ☐ Family

Do you have any eligible dependents, including a spouse? ☐ Yes ☐ No

If yes, provide the following information below to enroll them. (Name, Gender (M/F), Birthday)
(*Attach Additional Sheets if Necessary)*

_____

_____

Monthly Vision Premium …… $_____
CARE Membership …….. $_1.00_____
Total Due Per Month …… $_____

I hereby apply for coverage under the Ameritas Life Insurance Corp. Dental/Vision Plan.

_____
Enrollee's Signature

_____/_____/_____
Date

Please Select and Check One of the Following Payment Methods

☐ VISA Monthly ☐ MasterCard Monthly

Please submit with one month's premium made payable to GIS

Expiration Date: ____/____/____

Name as it appears on the card: _____

Account # __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Cardholders Signature: _____

☐ Personal Account Insurance Deduction (P.A.I.D.)
(Arranged by Greater Insurance Service Corp)

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.

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

WITHDRAWAL AUTHORIZATION
Name of Depositor _____
(Print name as shown on Financial Institution Records)
To Financial Institution _____
(Address of Institution or Branch where account is maintained)

GISC ONLY:
TRANSMIT/ROUTING ABA#_____
ACCT. NO. _____

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 premium owed on policies I currently have or may purchase and desire to include under the P.A.I.D. 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