New for the Academy of Model Aeronautics

Stand Alone Vision Plan
-Vision Perfect-

Coverage For:

Exams - Frames - Lenses - Contact Lenses

Freedom to choose your own eye care provider without being penalized!

Monthly Premium

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

*Eligible applicants must be a member in good standing of the Consolidated Association of Resolute Employers (CARE)

For More Information Call 800-747-4472

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 refracture 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

Ameritas 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*

(Please Print Clearly)

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

Phone: _____ **Requested Effective Date:** _____

Birthday (mm/dd/yyyy): _____

Affiliation (If Applicable): _____

Coverage Enrolling In (check one):

Home Address: _____

☐ Insured Only ☐ Insured & 1 (child or spouse) ☐ Insured & 2 or more

_____
(CITY) (ST) (ZIP)

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

***Social Security #:** _____

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

Monthly Vision Premium ..... $_____
CARE Membership Fee ..... $ 1.00
Total Due Per Month ..... $_____

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

_____ _____/_____/_____
Enrollee's Signature *Date*

See Reverse Side For Payment Options

CARE SAV AMA 1-06

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.Ds

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 ☐ 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)

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 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