



## Eye Care Enrollment Form

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

*(Please Print Clearly)*

**NAME:** \_\_\_\_\_  
(FIRST) (M.I.) (LAST)

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
(CITY) (ST) (ZIP)

**\*SOCIAL SECURITY #:** \_\_\_\_\_ **BIRTHDAY (mm/dd/yyyy):** \_\_\_\_\_

**\*Social Security Number is Needed for your Claim Information**

**PHONE:** \_\_\_\_\_ **REQUESTED EFFECTIVE DATE:** \_\_\_\_\_

**EYE CARE COVERAGE ENROLLING IN (check one):**

☐ SINGLE ONLY    ☐ INSURED AND ONE    ☐ INSURED AND 2 OR MORE

**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*

\_\_\_\_\_  
\_\_\_\_\_

**CALCULATE TOTAL MONTHLY PREMIUM FOR PLAN(S) CHOSEN**

Monthly Vision Premium ..... \$ \_\_\_\_\_

CARE Monthly Membership Dues... + \$ 1.00 \_\_\_\_\_

Total Monthly Premium ..... = \$ \_\_\_\_\_

**I hereby enroll in the CARE Eye Care Plan through Ameritas Group Dental and Eye Care. I also understand that I am enrolling in a CARE membership.**

\_\_\_\_\_  
*Enrollee's Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

**See Reverse Side For Payment Options**

# **Greater Insurance Service Corp. Payment Option Form**

## **Please Complete the Following Information**

*Please Print*

Insured Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City ST ZIP

## ***Please Select and Check one of the Following Payment Methods***

☐ VISA Monthly ☐ MasterCard Monthly

There is a 4% service fee for this option.

### **Instructions for Credit Cards**

1. Please complete the following account information and return with a check made payable to Greater Insurance Service for one month's premium
2. Credit cards will be charged around the 20th of the month for the next month's premium (\*see example at bottom)

Account # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_

Name as it appears on the card: \_\_\_\_\_

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 voided check (no deposit slips) and a check for one month's premium made payable to GIS.
- 2.-Premium will be deducted around the 15th of each month for the next month's premium (\*see example at bottom)

### **Please Select the Account Type for Withdrawal**

WITHDRAWAL AUTHORIZATION

☐ **Checking Account** ☐ **Savings Account**

Name of Depositor \_\_\_\_\_  
(Print name as shown on Financial Institution Records)

Bank Information \_\_\_\_\_  
(Bank Name, Address and Phone # where account is maintained)

TRANSMIT/ROUTING ABA# \_\_\_\_\_ ACCT. NO. \_\_\_\_\_

### **PRE-AUTHORIZED WITHDRAWAL PAYMENT METHOD**

As a convenience to me, I hereby request and authorize Greater Insurance Service Corp. to pay and charge to my account, maintained at the above named financial institution, for the payment of premiums due on policies I currently have or may purchase and desire to include under the P.A.I.D. Agreement. The amounts will be drawn on my account by and payable to the order of Greater Insurance Service Corp. provided there are sufficient funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing and until Greater Insurance Service Corp. actually receives such notice. I agree that Greater Insurance Service Corp. shall be fully protected in honoring any withdrawals. I understand that if the withdrawal is presented and not honored for any reason and the amount due is not paid, 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

**\*An example of deductions is as follows: July's premium will be deducted June 20th for Credit Cards or June 15th for PAIDS.  
If you have any questions, please call our office at 1-800-747-4472.**