Please Select and Check One of the Following Payment Methods

☐ VISA Monthly ☐ MasterCard Monthly

There is a 4% service fee for this option.

1. Please submit one month's premium made payable to GIS
2. Premiums will be charged around the 20th of each month for the next month's premium.

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)

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 around the 15th of each month for the next month's premium.

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)

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

FREQUENTLY ASKED QUESTIONS

When will my plan take effect? *Effective dates are based on when your enrollment and first month's premium is received.*

Can I really go to any dentist? *Yes, benefits are payable to any licensed dental provider. Dentists can call Ameritas prior to treatment to verify how the claim will be paid. But if you use one of our approximately 60,000 PPO dentists nationwide, you could receive even greater savings. Visit www.ameritasgroup.com to get a listing.*

Can I participate in this plan along with the dental plan I currently have? *Yes, this plan will have a true coordination of benefits. After your claim is coordinated with other insurance companies and if the claim payment exceeds billed charges, our* ***Dental Bank Feature*** *creates an account for your future dental needs.*

MONTHLY PREMIUMS

Value

Single Only	$21.60
Insured & One (Spouse or Child.....	$39.96
Insured & 2 or more.....	$59.40

Standard

Single Only	$30.80
Insured & One (Spouse or Child)	$56.68
Insured & 2 or more.....	$82.80

Royal

Single Only	$39.28
Insured & One (Spouse or Child)	$72.24
Insured & 2 or more.....	$106.04

*Above rates include appropriate fees.

Call for More Information

Plan Marketed By:

(Third Party Administrator)

Greater Insurance Service

414 Atlas Ave
Madison, WI 53714
Phone: 800-747-4472 Fax: 608-221-0868

Made Available Through:

CARE

1819 Clarkson Road, Suite 301
Chesterfield, MO 63017

Dental and Eye Care Insurance Underwritten By:

AMERITAS GROUP
We're Ameritas. We're for people.™
A Division of Ameritas Life Insurance Corp.
A UNIFI Company

PO Box 82520
Lincoln, NE 68501
Claims Number: 800-487-5553
www.ameritasgroup.com

Form: CAREDental (08/07)

Dental/Eye Care

CARE

Consolidated Association of Resolute Employers
1819 Clarkson Road, Suite 301
Chesterfield, MO 63017

DENTAL BENEFITS

Value, Standard and Royal Plans Benefit Outline—Over 250 Covered Procedures

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

Elimination Period—*12-month* waiting period on Major Procedures

Plan Maximum— *$1,000* per Calendar Year-Per Person **(This is a combined maximum for dental and eye care)**

* Dental Rewards ®—If within a calendar year an individual goes to the dentist at least once and never uses more than $500 of the plan maximum, the plan maximum will increase an additional $250 for the next year. This will continue to build up to a maximum total of $2,000 ($1,000 annual maximum, plus $1,000 maximum carryover) as long as the two provisions are met. If the member does not submit a covered claim during the calendar year, they will lose their accumulated carryover benefits and will not earn any for that year. If the member exceeds the $500 threshold, they will not lose any accumulated carryover, however they will not earn any additional carryover for that year.

Make sure you add up the benefits for each procedure performed to get the total benefit amount for one dental visit!

Insurance Pays 100% of schedule *-Sample Schedule of Benefits -*	Value	Standard	Royal
Preventive - NO DEDUCTIBLE			
Two evaluations per calendar year	$13 each	$16 each	$20 each
Two cleanings per calendar year—Adult	$33 each	$40 each	$50 each
Two cleanings per calendar year—Child	$22 each	$27 each	$34 each
Fluoride for Children (Under age 19)	$13	$15	$19
Basic			
X-rays—complete series (including bitewings)	$40	$48	$60
Bitewings—two films (Twice in a Benefit Period)	$15	$18	$22
Amalgam restoration (silver fillings)—one surface, primary or permanent	$35	$42	$53
Extraction—Erupted tooth or exposed root (elevation and/or forceps removal)	$40	$48	$60
Surgical removal of tooth (completely bony)	$83	$100	$125
Deep sedation/general anesthesia	$116	$140	$175
Major			
Maxillary partial denture—resin base	$248	$300	$375
Denture repair-Repair Broken Base	$30	$36	$45
Endodontics—root canal, anterior	$132	$160	$200
Periodontal scaling and root planing, four or more teeth. Each quadrant is eligible for consideration once in a 2 year period	$43	$52	$65
Crown—full cast noble metal	$185	$224	$280
Crown repair	$50	$60	$75
Pontics—porcelain fused to noble metal	$185	$224	$280

EYE CARE BENEFITS

-$0 Deductible

-Benefit - 100% up to a maximum of $100 and is deducted out of the total $1,000 maximum allowed for dental benefits

You can go to any licensed vision provider but you will receive extra discounts if you go to an EyeMed provider.

Exams—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.

Frames

Lenses—Single; Bifocal; Trifocal; No line bifocal or progressive power; Lenticular

Contact Lenses

-Laser Vision Correction Coverage - If an Insured undergoes or receives a Covered Procedure rendered by a Provider, the policy will pay benefits as stated below. Benefit Amount Payable For Covered Procedures Per Insured Person

Lifetime Maximum Benefit per Eye:For Covered Procedures, we will pay the lesser of the Provider's actual charge or the following benefit amount that corresponds to the Benefit Period in which the Covered Procedure was performed:

1st Benefit Period	2nd Benefit Period
$0 per eye	$100 per eye
3rd Benefit Period	**4th+ Benefit Period**
$250 per eye	$500 per eye

For More Information on Benefits

Call 1-877-817-4805 or visit

www.gisconline.com/dental

**For a listing of plan limitations and exclusions visit www.gisconline.com/dental or review your policy certificate once enrolled.*

Dental/Eye Care Plan 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)

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 Enrolling In (check one):

☐ Value ☐ Standard ☐ Royal

Coverage Enrolling In (check one):

☐ Single Only ☐ Insured & 1 (Spouse or Child)

☐ Insured & 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

_____ _____

Monthly Dental Premium ... $ _____

CARE Membership Fee .... + $1.00/Month

Total Due Per Month..... = $ _____

I hereby enroll in the CARE Dental/Eye Care Plan.

_____ ___/___/___

Enrollee's Signature ***Date***

_____

Agent Signature (If Applicable)

See Reverse Side For Payment Options

Form UpdatedCAREDental 08/07