

Enroll Today!

Stand Alone Eye Care 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 Greater Insurance Service at 877-817-4805

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 (<i>Frames and Contact Lenses Benefits cannot be used in the same 12 month period</i>) | \$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 (<i>Frames and Contact Lenses Benefits cannot be used in the same 12 month period</i>) | \$110.00 |

* For a listing of plan limitations and exclusions visit <https://www.gisconline.com/tlw> or review your policy certificate once enrolled

Ameritas 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: _____ Phone: _____ Requested Effective Date: _____
(FIRST) (M.I.) (LAST) Birthday (mm/dd/yyyy): _____

Affiliation (If Applicable): TLW Coverage Enrolling In (check one):

Home Address: _____
(CITY) (ST) (ZIP) Insured Only Insured & 1 (child or spouse) 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)

*Social Security #: _____

Attach Additional Sheets if Necessary

*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. Eye Care 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

CARE TLW VA 3-07

Please Select and Check One of the Following Payment Methods

- VISA Monthly** **MasterCard Monthly**

There will be a 4% of premium billing 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)

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

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)

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