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, <u>INCLUDING A SPOUSE</u>? ☐ YES ☐ NO

IF YES, PROVIDE THE FOLLOWING INFORMATION TO ENROLL THEM:
<u>(Name, Gender (M/F), Birthday)</u> *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***

<u>See Reverse Side For Payment Options</u>

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.**

Form: GIS Payment 7-08