Dental and/or Vision Enrollment Form

To enroll, *complete the following form and mail along with your payment to: Central Biling 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 Policy Number**

PHONE: _____ **REQUESTED EFFECTIVE DATE:** _____

PLAN(S) ENROLLING IN (CHECK 1 DENTAL AND/OR 1 VISION)

☐ Dental - Low Plan ☐ Dental - High Plan

☐ Vision - ViewPointe—EyeMed ☐ Vision - Focus—VSP

DENTAL AND/OR VISION COVERAGE ENROLLING IN (check one):

☐ SINGLE ONLY ☐ INSURED & CHILD ☐ INSURED & SPOUSE ☐ FAMILY

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 Dental Premium …… $ _____

Monthly Vision Premium …… + $ _____

Total Monthly Premium ……..... = $ _____

I hereby enroll in the Ameritas Life Insurance Corp. Dental and/or Vision Plan(s).

_____ _____/_____/_____

Enrollee's Signature ***Date***

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

GIS Benefit Center Payment Option Form

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.

Instructions for Credit Card

1. Please complete the following account information and return with a check made payable to GIS Benefit Center for one month's premium
2. Credit cards will be charged around the 20th of the month for the next month's premium

ACCOUNT # ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

EXPIRATION DATE: _____/_____

NAME AS IT APPEARS ON THE CARD: _____

CARDHOLDER'S SIGNATURE: _____

☐ **Electronic Funds Transfer (EFT)** Arranged by GIS Benefit Center

Instructions for EFT

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 coverage.

Please Select the Account Type for Withdrawal ☐ Checking Account ☐ Savings Account

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. _____

PRE-AUTHORIZED WITHDRAWAL PAYMENT METHOD

As a convenience to me, I hereby request and authorize GIS Benefit Center 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 EFT Agreement. The amounts will be drawn on my account by and payable to the order of GIS Benefit Center 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 GIS Benefit Center actually receives such notice. I agree that GIS Benefit Center 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, GIS Benefit Center 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

Form: NEFBF APP 7-17