CARE Benefits Program Enrollment Form

Complete form along with Payment Option Form and return to the address at the bottom with a check for the first month's premium

Group Name: CARE Group Number: B00164-04

Member (Last, First, M.I.)	☐Male ☐Female	Social Security No.	Date of Birth	Date of Marriage***
Spouse** (Last, First, M.I.)	☐Male ☐Female	Social Security No.	Date of Birth	
Home Address		Employer Name		Date of Hire
City	State	Zip Code	Home Phone	

Child(ren) Name	Date of birth	Gender	Student	Child(ren) Name	Date of birth	Gender	Student
		☐M ☐F	☐Yes ☐No			☐M ☐F	☐Yes ☐No
		☐M ☐F	☐Yes ☐No			☐M ☐F	☐Yes ☐No

Primary Beneficiary: (Last, First, M.I.)	Relationship:
Contingent Beneficiary: (Last, First, M.I.)	Relationship:

Member will be the beneficiary for any spouse** and/or child(ren) coverage

Do you choose to enroll in the Limited Medical Indemnity Program ☐Yes ☐No If Yes: ☐Freedom ☐Liberty

I am enrolling in: ☐Member ☐Member Plus Spouse** ☐Member Plus Children ☐Member Plus Family

*Premium includes TransChoice Premium, CARE fee and Billing/Administration Fees

Monthly Premium*
$

Medical Eligibility Question

1. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? ☐Yes ☐No

If "Yes", list name (s)_____, who will be excluded from coverage

Do you choose to enroll in the Dental Coverage ☐Yes ☐No If Yes: ☐Value ☐Standard ☐Royal

I am enrolling for: ☐Member ☐Member Plus Spouse** ☐Member Plus Children ☐Member Plus Family

*If you are not enrolling in the Medical Program, you must add $1 to your dental Premium for the CARE membership fee.

Monthly Premium
$

Do you choose to enroll in the Eye Care Coverage ☐Yes ☐No

I am enrolling for: ☐Member ☐Member +1 ☐Member + 2 or more

*If you are not enrolling in the Medical Program, you must add $1 to your Eye Care Premium for the CARE membership fee.

Monthly Premium
$

Applicant's Statements and Agreements:

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached. I understand that any person whoknowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects person to criminal and civil penalties

I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of mMembers; b) I must have satisfied the Association waiting period; c) the Association group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively

By signing this I am also enrolling in the CARE association and understand that I must keep this membership in good standing to keep this insurance.

Signed in (City/State) _____ This _____ Day of (Month/Year)_____

Member's Signature _____ Spouse's** Signature (If applicable)_____

Licensed Representative's Name_____ Licensed Representative's Signature _____ Agent #_____

Please send this enrollment form, along with your first month's premium to:

GIS Benefits Center
P.O. Box 8633
Madison, WI 53708-8633

CBPCARE-02-09

**Spouse or equivalent, as defined by governing state law. ***Marriage or equivalent, as defined by governing state law.

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

ENROLLMENT STEPS

Please complete the following easy steps to enroll in this great new benefit:

To Enroll By Mail:

STEP 1
Complete, Sign and Date Enrollment form. Be sure to include information on all individuals to be covered.

STEP 2
Complete, Sign and Date the Payment Options Form.

STEP 3
Write a Check made payable to GIS for the first month's premium.

STEP 4
Return the following items to: GIS Benefits Center
PO Box 8633
Madison, WI 53708-8633

1. Completed Enrollment Form
2. Completed Payment Option Form
3. Check made payable to GIS for one month's premium

To Enroll Online:

Go to https://gisconline.com/cbp
-Credit Card payment is the only option if you enroll online

For Questions:

If you have any questions on the
enrollment process or payment options, please contact
GIS Benefits Center at
1-877-817-4805

If you have any questions on
specific policy benefits, please contact
Transamerica-KBA at
1-866-867-6883