

## **CARA Ameritas Dental** **Enrollment Instructions**

- Complete the **Employer Application** form and select *ONE* plan design for the entire employer group.
- Each enrolling employee needs to complete an **Employee Application**.
- If the enrolling employee does not elect to cover their dependents, then dependents may not enroll later unless there is a qualifying event.
- All employer groups will be made effective on the first of any given month.
- This plan focal renews on **July 1** of every year.
- Include first month's premium check and applicable billing fee. Make check payable to **CARA**.
- Submit all forms to AIS for processing:  
**AIS**  
**One Kaiser Plaza, Suite 1333**  
**Oakland, CA 94612**  
**Attn: New Business**
- For questions, call AIS at (800) 788-6524.

# CARA Ameritas Dental

## Employer Application

### Employer Group Information

Effective Date :

Group Name :		
Address :		
City :	State :	Zip Code :
Contact Person:		
Phone :	Fax :	
Email :		

### Monthly Rates Effective Through 6/30/2009

Select Only One (1) Plan Design per Employer Group

	<input type="checkbox"/> Plan 1 - \$1000 Max	<input type="checkbox"/> Plan 2 - \$1250 Max	Number of Employees
Employee Only	\$ 25.68	\$ 34.00	
Employee + 1	\$ 47.12	\$ 63.84	
Employee + 2 or More	\$ 73.20	\$ 106.20	
Subtotal			\$
Administration Fee *			\$
Grand Total			\$

ACH   
  Monthly   
  Quarterly   
  Semi-Annually   
  Annually

Note: ACH groups – Please complete the ACH form.

Please make check payable to “CARA”

\* Please refer to *AIS Administration Fee Schedule* for your choice of billing option.

### Broker Information

Broker Name :		
Firm Name :		
Address :		
City :	State :	Zip Code :
Phone :	Fax :	
Email :		
Tax ID # or SSN # :		

### General Agent Information

GA Name :
GA Firm Name :

**Please mail to: AIS \* One Kaiser Plaza, Suite 1333 \* Oakland, CA 94612 \* Attn: New Business**

# CARA Ameritas Dental Employee Application

New Enrollment     
  Add Dependent(s)     
  Address Change     
 Effective Date :

### Employer Group Information

Group Name :

Group # or Client # :

### Employee Information

SS # :                                      Date of Birth :                                      Sex :  Male     Female

Last Name :                                      First Name :                                      M. I. :

Address :

City :                                      State :                                      Zip Code :

Marital Status :  Single     Married     Divorced     Widowed

**Select Coverage :**     Employee Only     Employee + 1     Employee + 2 or More

Spouse

Last Name :                                      First Name :

Domestic Partner

Sex :  Male     Female                                      Date of Birth :

SS # :

Child # 1

Last Name :                                      First Name :

Sex :  Male     Female                                      Date of Birth :

Full Time Student :  Yes     No                                      Disabled :  Yes     No

Child # 2

Last Name :                                      First Name :

Sex :  Male     Female                                      Date of Birth :

Full Time Student :  Yes     No                                      Disabled :  Yes     No

Child # 3

Last Name :                                      First Name :

Sex :  Male     Female                                      Date of Birth :

Full Time Student :  Yes     No                                      Disabled :  Yes     No

Check here  if additional sheet(s) is attached with this application

**X**

**Applicant Signature**

**Date**

Distributed By :

Benefit Logic, Inc.  
1500 E. Cedar Ave. Ste. 78  
Flagstaff, AZ 86004  
800-359-5176

Administered By :

AIS  
One Kaiser Plaza, Suite 1333  
Oakland, CA 94612  
Phone : 800.788.6524  
Fax : 510.893.4445  
[www.ais-insurance.com](http://www.ais-insurance.com)

**AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)**

**E.W.C. INSURANCE SERVICES, INC. DBA AIS**

I (we) hereby authorize E.W.C. Insurance Services, Inc. DBA AIS, hereinafter called COMPANY, to initiate *debit entries* to my/our CHECKING account indicated below at the Depository Financial Institution named below, hereinafter called DEPOSITORY, and to debit the same to such account on the  5<sup>th</sup> or  20<sup>th</sup> of each month (select one). I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

DEPOSITORY NAME \_\_\_\_\_ BRANCH \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

ROUTING# \_\_\_\_\_ ACCOUNT# \_\_\_\_\_

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) \_\_\_\_\_ CLIENT # \_\_\_\_\_  
FOR INTERNAL USE ONLY

DATE \_\_\_\_\_ SIGNED X \_\_\_\_\_

*NOTE: All written debit authorization MUST provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization within 30 days. This form is to be submitted along with 1<sup>st</sup> month's premium and/or a copy of 'VOID' check.*

*sample check*

Any Name 1234 Any Street City, State Zip Code	DATE _____	2345
Pay to the order of _____	_____ Dollars	
<b>Bank Name</b> Main Branch 1234 Any Street City, State Zip Code (800) 555-1234	_____	
Ⓘ:123456789Ⓘ: 2345 @ 1234567890		
↑ Routing Number	↑ Account Number	

Depository Name →  
Branch →

# CARA Membership Application

The undersigned, whose address and telephone number are shown below, hereby makes application for membership in CARA, an unincorporated association, upon the terms and conditions herein provided.

Upon payment of the membership application fee in the amount of \$15.00 and acceptance by CARA, the undersigned shall be entitled to all privileges and benefits as a CARA member, including participation in all CARA sponsored insurance programs for which such member shall be qualified and accepted.

In order to sustain membership in CARA, the member shall pay to CARA each year on or before the anniversary date of enrollment shown below, the annual dues established by the CARA Board of Directors. Said association dues shall be used by CARA solely for and in consideration of membership in the association.

The undersigned agrees to abide by the association's laws and such other membership rules as may be promulgated by the CARA Board of Directors from time to time.

Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

For internal use:  
Accepted by CARA \_\_\_\_\_  
Signature

# AIS

(In Nevada, also known as EWC Insurance Services, Inc.)

## Administration Fee Schedule

<b>Monthly</b>	<b>ACH (Auto Bank Draft) <sup>1</sup></b>	<b>By Mail</b>
1 to 4 Employees	\$ 3.50	\$ 10.00
5 > Employees	\$ 3.50	\$ 20.00
CARA Annual Fee <sup>2</sup>	Waived	\$ 15.00

### Other Billing Options:

<b>By Mail</b>	<b>Quarterly</b>	<b>Semi-Annually <sup>3</sup></b>	<b>Annually</b>
1 to 4 Employees	\$ 20.00	\$ 25.00	\$ 25.00
5 > Employees	\$ 30.00	\$ 25.00	\$ 25.00
CARA Annual Fee <sup>2</sup>	\$ 15.00	\$ 15.00	\$ 15.00

**Please make check payable to “CARA”.**

<sup>1</sup> ACH groups will not receive any monthly statements.

<sup>2</sup> CARA Annual Fee is due on anniversary month.

<sup>3</sup> SINGLE employee groups requesting “Mail Billing” are required to pay semi-annually.