DIRECT DEPOSIT 1199A | **SIGN-UP FORM**

EMPLOYEE INFORMATION | **Payroll Allotment and membership application**

Name (Last, First, MI) as it appears on your pay check:	[ ]Start Allotment Deduction to start: As Soon As Possible [ ] Change Allotment I am a: Federal Employee [ ] Postal Employee [ ] Retired [ ] Federal Judges and some IRS Employees may have deductions converted to a once a month deduction This form does not involve your personal bank account. **From** ____ **To** ____
Address:	
Social Security #	**Bi-weekly Allotment Amount**: **$** — Type of Depositor Account: [x] Savings
Agency	Account Number (Federal Employees only use this #) **[ ] Federal Employee 0 9 1 2 0 2 8 8 1 8**
Work Address:	Account Postal Employees >at the end **add your Social Security** # **[ ] Postal Employee CGS 0 2 2 5_**
Telephone #	**Employee Certification:** I certify that I am entitled to the payment identified and that I have read and understand this form. In signing this form, I authorize my payment to be sent to the financial institution named to be deposited to the designated account. **X**
Email:	
Postal Employee Finance Number:	**Employee Signature**: — Date:

FINANCIAL ORGANIZATION INFORMATION

[ ]**Federal Employee** **F**inancial **I**nstitution WellsFargo **Routing # 121042882** | [ ]**Postal Employees** **F**inancial **I**nstitution Bank America **Routing # 011900445**

Authorized By I confirm the identity of the above named payee and the account number. As representative of the above named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and/or 210. Signature: X *Bruce Benin* Bruce Benin Vice President

The collection of the information you are requested to provide on this form is authorized under 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment date from the Federal agency to the financial institution.

Allotment Authority for Insurance…Please return a copy of this form even if you have processed with payroll. You are hereby requested to establish an account in my name to designated insurance savings trust escrow account. I understand that this account will be used solely for the purpose of receiving monies from my employer for the payment of insurance and will be non-interest bearings to me. If premiums change and the client does not change deduction for dental fees the plan may be change to reflect the lower deduction. This will institute an allotment from my pay to bank for deposit to my insurance account. I hereby authorize and empower you for and on behalf, to deposit each month if available from insurance /savings/checking trust account. I hereby authorize and empower you for and on my behalf, to deposit each pay period or converted to monthly, if available from my insurance/savings trust escrow account the funds I have authorized. These instructions and authorizations may be cancelled or amended at any time upon receipt by bank or assignee of either written notice by me or an executed copy of U.S. treasury allotment form or other forms as modified by the US treasury bearing my signature. Did you give to your Employer? [ ] Yes [ ] No or Go online to add? [] Yes [ ] No

If you turn into payroll return copy to the administrator

X ______________________________ Date ________________ Fax 818-223-8147 or Fax 818-223-9651 www.fdvp.com

Employee Signature Email: info@federaldentalportal.com

Application American Federal Employees Group Membership with Ameritas (any doctor or use PPO) or Dental DHMO that is unrelated to Ameritas Group

Last, First MI as in appears on payroll or retired records

Name:__________________________ DOB: __________Social Security #: _______________**Plan:** _________ # of Children Covered: ____ _______

Address: ______________________________City ________________ State ____ Zip&4 ________ Home Phone ________________ ____________________

Mailing address if different ______________________________________ **DDS Code#** DDS Office(FOR DHMO only] ______________

Employer: _______________ Work Address ______________________________________ Work Phone ________________

Primary Email ________________________ if a union member name & local #: ______________ Spouse: __________________ DOB __________

Child(ren) Name & Date of Birth(s): ____

____ company use Premium Mode _____ Paid:

Additional member coverage is only for the DHMO Not the Free Choice Ameritas with PPO go online for accessing provider link, bank draft, and other information. I hereby authorize any required payroll deductions from my earnings for any required contribution. This authorization remains in effect until revoked by me in writing. I understand that this enrollment is for a minimum of 12 months. If premiums change and the client does not change deduction for dental fees the plan may be change to reflect the lower deduction. Please, sign to accept membership for AFEGA and coverage even when no payroll deduction. I hereby apply for coverage..

No, we are not going to bug you.

Applicant for membership and coverage **Signature X**__________________________ Date ________ Interested in? [ ] Disability [ ] Cancer [ ] Life

Return to AMA 23901 Calabasas Rd. Suite 2014 Calabasas, CA 91302 **818-223-9750** fax 818-223-8147 **www.fedvp.com** Email: ***info@fedvp.com***

Bank Draft from your bank account *Check-O-Matic* for Personal Account Insurance or Plan Deduction

AMERICAN MARKETING ADMINISTRATORS, INC A Registered Insurance Administrator *Since 1980*

As a convenience to me, I request and authorize YOU to pay and charge to my account checks drawn on the account by and payable to the order of AMERICAN MARKETING ADMINISTRATORS, INC. (hereafter referred to as AMA) provided there is a sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I authorize AMA to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of any required premium and or fees due for requested coverage and plans. This authority is to remain in effect until revoked by me, in writing, by US Mail and until you actually receive such notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no

liability whatsoever even though such dishonor results in forfeiture of coverage and fees for dishonored checks.

Name of Bank or Financial Institution .. name on the account

Subscribers Social Security #

Street

Name on Checking Account if different then above

____

City, State Zip code

ROUTING ABA# (firs 9 #s)______________________________

NOTE: You will incur a service charge for any withdrawal Not honored. You may be billed quarterly.

Account # (do not include a check number) ______________________________

Authorized Signature (As it appears in the financial institution's records)

TYPE OF ACCOUNT:
[]Checking or [] Savings Premium Mode:
[]Expedite Enrollment []Enrollment Fee
[]Premium

X ______________________________ Date

>A Voided check (or copy of a voided *(not a deposit slip)* mail or fax in to expedite <

Fax 818-223-8147 alternate Fax 818-992-4438

AMERICAN MARKETING ADMINISTRATORS, Inc. (AMA) **818-223-9750**

23901 Calabasas Road Suite 2014 Calabasas, CA 91302-3307

Email: info@fedvp.com web site www.fedvp.com

Enrollment fee and 2 months bank draft premium: Name of person paying:

EMPLOYEES NAME if different: ______________________________

Subscribers to be covered:

Primary: ______________________________ Social Security # ____________________ Date of Birth __________

Spouse: ______________________________ Date of Birth ____________

Child: ________________________ date of birth __________ Child __________________ Date of Birth ________

Child: ________________________ date of birth __________ Child __________________ Date of Birth ________

Child: ________________________ date of birth __________ Child __________________ Date of Birth ________

Child: ________________________ date of birth __________ Child __________________ Date of Birth ________

Over Age Children, Parents, Siblings, etc. will pay the premium of a single adult

Additional Persons Name: Social Security # Date of Birth

Authorization:

[]Expedite Enrollment X______________________________ Date
[]Enrollment Fee

Bank Draft from your bank account or Credit Card authorization

Check-O-Matic for Personal Account Insurance or Plan Deduction

AMERICAN MARKETING ADMINISTRATORS, INC A Registered Insurance Administrator *Since 1980*

As a convenience to me, I request and authorize YOU to pay and charge to my account checks drawn on the account by and payable to the order of AMERICAN MARKETING ADMINISTRATORS, INC. (hereafter referred to as AMA) provided there is a sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I authorize AMA to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of any required premium and or fees due for requested coverage and plans. This authority is to remain in effect until revoked by me, in writing, by US Mail and until you actually receive such notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage and fees for dishonored checks.

Name of Bank or Financial Institution

Street

City, State Zip code

NOTE: You will incur a service charge for any withdrawal Not honored. You may be billed quarterly.

TYPE OF ACCOUNT:
[]Checking or [] Savings Premium Mode:
[]Expedite Enrollment []Enrollment Fee
[]Premium

WITHDRAWAL AUTHORIZATION Subscribers Name

Subscribers Social Security #
Name on Checking Account if different then above

____

ROUTING ABA# (firs 9 #s)_________________________________

Account # (do not include a check number) ___________________________

Authorized Signature (As it appears in the financial institution's records)

X ________________________________ Date

>A Voided check (or copy of a voided *(not a deposit slip)* mail or fax in to expedite <

Fax 818-223-8147 alternate Fax 818-992-4438 818-223-9750

AMERICAN MARKETING ADMINISTRATORS, Inc. (AMA)

23901 Calabasas Road Suite 2014 Calabasas, CA 91302-3307

Email: info@fedvp.com **Web site www.fedvp.com**

You may also mail a check for the enrollment fee, or the enrollment fee and 2 months bank draft premium as shown in the brochure and avoid additional charges.

CREDIT CARD PAYMENT

Name as it appears on Credit Card: ____

Billing Address on your Credit Card: ____

Type of card (only VISA or Master Card MC): ___________________________________

Credit Card #: ______________________________ Credit Card Expiration Date: _____________

Last 3 digits of security code from the back of the credit cars:____________________________

Authorization:

[]Expedite Enrollment X Date
[]Enrollment Fee
[]Premium

PostalEASE is for Postal Employees Only: ***DHS & TSA use National Finance Center (NFC) ; other federal agencies use Employee Express***

Federal Employee Health Benefit Program

RI 70-2 For United States Postal Service Employees

FEHB and PostalEASE

The United States Postal Service is now using PostalEASE to enter Federal Employee Health Benefit (FEHB) Program Open Season enrollments and changes. By using PostalEASE for health benefits, and by sending information to health insurance companies electronically instead of via paper forms as in past open seasons, the Postal Service expects that employees who make health benefits changes will get their new insurance cards more quickly. All the information you need for using PostalEASE is included in the FEHB PostalEASE Worksheet found on pages 19 to 21 of this Guide. Just follow the instructions to:

Enroll Change Enrollment Cancel Enrollment Review or change your pending open season transaction Review or update your dependent information Review your current enrollment information Receive a copy of a health benefits election that was processed using PostalEASE

Please do not wait until late in the open season to enter your choice via PostalEASE. If you select Self and Family coverage, then you'll need to enter information about your dependents. Although this will take extra time, providing this information is required under FEHB regulations. Just complete the FEHB PostalEASE Worksheet and follow the instructions carefully.

All open season Self Only enrollments, changes to Self Only coverage, and cancellations, should be entered as employee "self service" transactions using PostalEASE. Since dependent information is not required, such transactions are simple. Most Self and Family enrollments can also be completed as employee self service transactions, although they require additional information. The easiest way to do this is via the PostalEASE Employee Web, which is available through the Blue page or on a kiosk. Many Self and Family transactions can also be completed by telephone. If you are unable to enter your dependent information via the telephone, the PostalEASE system will refer you to the Web, a kiosk, or your local personnel office. PostalEASE provides the enrollment date, processing date, and effective date when you complete your transaction. You may delete or change a pending transaction until it is processed. If you are newly eligible for FEHB as a career employee, you may also use PostalEASE during the first 60 days after your date of appointment.

This Guide contains important FEHB policy information that used to be provided to you as part of the SF 2809 Health Benefits Election Form. Be sure you understand how your health benefits work, including information on which family members are eligible, how you pay for your health benefits premiums using pre-tax dollars, and the limitations on making a health benefits change outside of open season. As a reminder, to continue health benefits coverage during retirement, you must have had five consecutive years of FEHB coverage immediately prior to your retirement. If you need help understanding any of this information, or you need help using PostalEASE, you should contact your local personnel office for assistance

.Dental and Vision Benefits through is open year round and will not close with open season

You may use PostalEASE to pay your dental and vision DHMO or Fusion Free Choice by Ameritas Group with administration by AMA at www.fedvp.com for questions contact:

Email: info@fedvp.com 818-223-9750 fax 818-223-8147 or 800-300-PLAN