Premiums

	Self	*Self+1*	*Family*
Bi-Weekly	$5	$9.50	$13.50
Monthly	$11	$20	$29
Quarterly	$32	$62	$89
Semi-Annually	$63	$122	$175
Annually	$124	$238	$340

**Premiums include administrative fees.*
**Please add a one-time $10 enrollment fee (this is waived if you are already a Dental Subscriber).*

Schedule of Benefits WITH Participating Provider

Eye Exam (with dilation):
- **100% after $10 co-pay**

Lenses (Single, bifocal, Trifocal), every 12 months:
- **100% after $15 co-pay**

Contact Lenses, every 12 months:
- **$130 annual allowance**

Frames, every 24 months:
- **$130 Retail allowance (20% thereafter)**

Schedule of Benefits: NON Participating Provider

Eye Exam:
- **$30 allowance**

Lenses:
- **Single: $25 allowance**
- **Bifocal: $40 allowance**
- **Trifocal: $60 allowance**

Contact Lenses:
- **$104 annual allowance**

Frames:
- **$65 retail allowance every 24 months**

LASIK discounts are also available through negotiated fixed pricing.

Introducing our Humana Vision Plan

We are offering members of our American Federal Employees Group (AFEG) a Vision Plan through *Humana Vision*. These vision benefits give you access to one of the largest vision networks nationwide, with 35,000 participating doctors.

Some of your benefits include:

- **Eye Exam 100% covered after co-pay**
- **Lenses 100% covered after co-pay**
- **$130 Annual Contact Lens allowance**
- **$130 Frame Allowance**
- **Negotiated discounts on LASIK**

A full list of benefits and limitations and exclusions are available on request by emailing info@fedvp.com or calling 818-223-9750/800-300-PLAN.

How it Works

Taking advantage of these great vision benefits is easy! Simply:

1. Sign up by filling out and sending in the application form, or online at www.fedvp.com.

2. Select a Network Provider at humanavision.com, or by calling 1-866-537-0229.

3. Schedule an appointment with your chosen optician.

4. Sign the Provider's form and pay your co-payment and/or upgrade costs.

Vision Plans

By Humana Vision

American Marketing Administrators, Inc.

23901 Calabasas Road, Ste 2014
Calabasas, CA 91302

818.223.9750
800.300.PLAN
info@fedvp.com
www.fedvp.com

Application for Membership & Enrollment in the American Federal Employees Group Association (AFEG) Vision Care Benefits

Name:	**DOB:**	**SS#:**
Home Address:		
Mailing Address (if different from above):		
Home Phone:		**Cell Phone:**
Email (never sold or given to others):		
Employer Name & Address:		
Work Phone:		**Work Fax:**
Spouse/Partner Name:		**DOB:**
Child(ren)/Dependent(s) Name(s) and DOBs:		**Premium Amount + $10 Enrollment Fee:** **$**

Payment Options (select one):

[ ] Bi-Weekly Federal or Postal Employee Payroll Deduction*

[ ] Monthly Credit Card (+4% fee) **[ ] Monthly Bank Draft** **[ ] Direct Billing: [ ] Quarterly [ ] Semi-Annual [ ] Annual**

**Eligibility takes 6-8 weeks on payroll. You can expedite this process and begin eligibility on the first day of the next month, by sending 2 months premium with your $10 enrollment fee.*

This authorization remains in effect until revoked by me in writing. I understand that this enrollment is for a minimum of twelve (12) months. If a future increase in premium requires a premium increase and I don't elect to do a premium increase I understand that my Plan will change. If coverage is stopped and then I wish to restart I may receive no prior credit and late enrollment reductions in benefits may occur. In several States we are required to advise you on the following: any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. As a Member, I hereby apply for the insurance benefits in the Plan's materials which I have read, or have had read to me and understand. I represent that the information I have provided is complete and accurate.

I understand that neither American National Dental Services nor American Marketing Administrators ("ANDS/AMA") represent or warrant the quality or competence of, or guarantee the services performed or results promised by, the dental or vision service provider in the plan.To the fullest extent permitted by law, I agree to limit liability of ANDS/AMA for any claims or damages I might incur in receiving dental or vision services, and that ANDS/AMA's liability shall not exceed the total compensation received by ANDS/AMA paid by me for the plan. It is intended that this limitation apply to any and all liability or cause of action however alleged or arising, unless prohibited by law.

Applicant for Membership and Coverage Signature: **Date:**

I am interested in receiving information on Dental Care Plans: [ ] Y [ ] N

I am interested in receiving information on Disability Insurance, or Individual/Group Medical Insurance: [ ] Y [ ] N

ENROLLMENT:

The regular starting date of eligibility is the **1st of the month**. However, if you pay by payroll deduction, your eligiblity will take place 6-8 weeks after receipt of your application and payment. If you would like to expedite your coverage on payroll deduction, please send 2 months premium, plus your $10 enrollment fee.These can be paid in one of the following ways:

1. Check: make checks payable to AMA and mail to: 29301 Calabasas Road, Ste. 2014, Calabasas, CA 91302-3307
2. Credit Card: fill out your details below and use your Visa or Mastercard (which will incur a 4% charge):
3. Automatic Bank Draft: fill our your details below and provide us with your 9-digit Routing Number and your Account Number

BI-WEEKLY FEDERAL & POSTAL EMPLOYEE PAYROLL DEDUCTION:

Your eligibility will begin 6-8 weeks following the receipt of this form and your online account details. To expedite this process, please follow the instructions above. Use the following information to set up payments through MyPay.com or EmployeeExpress.com, or your employer's payroll solution:

FEDERAL EMPLOYEES

- Wells Fargo #: 121042882
- Account #: 0912028818
- Account Type: Savings

POSTAL EMPLOYEES

- BOA Routing #: 011900445
- Account #: CGS0225- then your SSN
- Account Type Savings

You are hereby requested to establish an account in my name to the designated insurance 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 bearing to me. This will institute an allotment from my pay to the bank for deposit to my insurance account. I hereby authorize and empower you for and on my behalf to deposit each month, if available, from insurance/savings/checking account. These instructions and authorizations may be cancelled or amended at anytime upon receipt by the bank or assignee of either written notice by me or an executed copy of the US Treasury allotment form as modified by the US Treasuring bearing my signature.

Signature: Date:

Mail this form and the application form to: AMA, 23901 Calabasas Road, Ste. 2014 Calabasas, California 91302-3307

CREDIT CARD PAYMENT (*please note: credit card payments incur a 4% charge*):

I hereby authorize AMERICAN MARKETING ADMINISRTATORS, INC. to charge my credit card the required preimium and/or fees due for the requested coverage and Plans. This authority is to remain in effect until revoked by me in writing by US Mail.

Credit Card Payment: [ ] Mastercard [ ] Visa Please Charge My Card For: [ ] Enrollment Fee [ ] 2 Months Premiums to Start [ ] Monthly

Name on Account: Credit Card #:
Expiry:

Billing Address:

Security Code:

Signature: Date:

Mail this form and the application form to: AMA, 23901 Calabasas Road, Ste. 2014 Calabasas, California 91302-3307

MONTHLY BANK DRAFT:

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. (AMA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each debit shall be the same as if it were a check drawn by you and signed personally by me. I authorize AMA to initiate debits (&/or corrections to previous debits) from my account with the financial institution indicated for payment of any required preimium &/or fees due for requested coverage & plans. This authority is to remain in effect until revoked by me, in writing, by US Mail & until you actually receive such notice. I agree that you shall be fully protected in honoring 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 & fees for dishonored checks.

Name of Bank/Financial Institution: Name on Checking Account:

Address: Routing ABA# (first 9 #s):

Account Number: Type of Account: [ ] Checking [ ] Savings

To Pay: [ ] Enrollment Fee [ ] 2 Months [ ] Continuous Monthly
Note: you will incur a service charge for any withdrawals not honored.

Signature: Date:

Date:

Mail this form and the application form to: AMA, 23901 Calabasas Road, Ste. 2014 Calabasas, California 91302-3307

DIRECT BILLING:

Mail a the application form and a check for the [ ] Quarterly [ ] Semi-Annual [ ] Annual premium amount for your chosen Plan, along with your $10 enrollment fee to: **AMA, 23901 Calabasas Road, Ste. 2014 Calabasas, California 91302-3307.** We will bill you according to your selected billing period thereafter.