DENTAL CARE

CALIFORNIA

FOR OUR AMERICAN FEDERAL EMPLOYEES GROUP.

PROVIDED AND ADMINISTERED WESTERN DENTAL SERVICES INC.

American Marketing Administrators, Inc.
23901 Calabasas Road, Ste. 2014
Calabasas, California 91302-3307
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AMERICAN MARKETING ADMINISTRATORS Inc
INSURANCE AGENCY

DEPENDENTS COVERED UP TO 26
ORTHODONTICS FOR CHILDREN AND ADULTS
PLANS INCLUDE COVERAGE FOR IMPLANTS

BI-WEEKLY PREMIUM FROM
$7 SELF ONLY
$9 SELF +1
$10 FAMILY

PLANS OPEN TO MEMBERS OF
AMERICAN FEDERAL EMPLOYEES
GROUP

Pre-Existing Conditions Covered, No Waiting Period for Major Dentistry

***Coverage Includes*: Implants, Dentures, Partials, Repairs, and Cosmetic procedures,**

Dental Plans provided and administered by *Western Dental Services Inc*

For a List of Participating Dentists please call 800-992-3366 or visit www.westerndentalbenefits.com

PLAN PREMIUMS

PAYROLL DEDUCTION BI-WEEKLY	**Plan 7750**	**Plan 7760**	**Plan 7780**
Self Only	$12.00	$11.00	$7.00
Self & 1 Dependent	19.00	16.00	9.00
Family	21.00	18.00	10.00
MONTHLY BANK DRAFT			
Self Only	24.00	22.00	11.00
Self & 1 Dependent	39.00	33.00	18.00
Family	43.00	39.00	20.00
ANNUAL DIRECT BILL			
Self Only	260.00	230.00	100.00
Self & 1 Dependent	442.00	350.00	180.00
Family	494.00	394.00	199.00
SEMI-ANNUAL DIRECT BILL			
Self Only	140.00	135.00	60.00
Self & 1 Dependent	231.00	195.00	108.00
Family	257.00	215.00	118.00
QUARTERLY DIRECT BILL			
Self Only	78.00	73.00	35.00
Self & 1 Dependent	125.00	99.00	63.00
Family	139.00	110.00	68.00

Premiums include administrative fees. Please add a one-time Membership & enrollment fee of $20 to your chosen Plan premium.

Dental Plans Provided by Western Dental Services Inc.

vision discount plan, offered through Coast-to-Coast Vision.

For a list of Participating Dentists please call 800-992-3366 or visit www.westerndentalbenefits.com

COAST-TO-COAST VISION CARE INCLUDED IN YOUR PLAN PREMIUM

1. Prescription Eye Wear Save 20-60%
Most frames, lenses, and specialty items (including tints, scratch resistant coatings and ultraviolet protection) are conveniently available at participating locations.

2. Replacement of Contact Lenses Save 10-40%
Most major brands of soft contact lenses are obtainable through the mail order service provided by America's Eyewear, including disposable, tonics, and E bifocals. Gas permeable materials are also available.

3. Ophthalmology Services Save 10-30%
Vision members receive discounts on eye exams at participating locations.

4. Laser Surgery Save 40-50%
Discount off the overall national average for laser eye surgery.

5. Fully-insured Vision Care Plansare available for an additional premium. Visit www.fedvp.com or call 818-223-9750/800-300-PLAN for more details.

You and your family can now save hundreds of dollars each year. There is no limit on quantities and no restrictions on selections. There is no paperwork or waiting. Prices may change without notice. Use this plan and SAVE MONEY!

To find the vision provider nearest you, call: 800-800-EYES, or visit www.mymemberportal.com

APPLICATION FOR MEMBERSHIP & ENROLLMENT IN THE AMERICAN FEDERAL EMPLOYEES GROUP ASSOCIATION (AFEG) DENTAL AND 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):		**DOBs:**
DENTIST NAME & DDS#: ***This can be found at www.westerndentalbenefits.com***	**Plan Selected:** **[ ] 7750 [ ] 7760 [ ] 7780**	**Premium Amount + $20 Enrollment Fee:** **$**

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 $20 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 you may lose coverage. 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 Vision Care Plans: [ ] Y [ ] N
I am interested in receiving information on Accident/cancer, Hospital or Individual/Group Health Insurance: [ ] Y [ ] N

PAYMENT INSTRUCTIONS

ENROLLMENT:
The regular starting date of eligibility is the **1st of the month**. However, if you pay by payroll deduction, your eligibility 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 $20 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 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 any time 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 premium 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 premium &/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 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:

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

DIRECT BILLING:
Mail the application form and a check for the [ ] Quarterly [ ] Semi-Annual [ ] Annual premium amount for your chosen Plan, along with your $20 enrollment fee to: **AMA, 23901 Calabasas Road, Ste. 2014 Calabasas, California 91302-3307.** We will bill you according to your selected billing period thereafter.