

A Dental & Vision Plan With You in Mind!



The Washington State School Retirees' Association has endorsed a group dental insurance and eye care plan for WSSRA members.

The WSSRA group dental insurance plan is underwritten by Ameritas Life Insurance Corp. You have the freedom to use your own dentist or you can select a network dentist that provides services discounted from 20-30%. The plan also includes first day benefits for preventative and basic services and Dental Rewards which can enable your \$1,500 maximum to grow to \$2,500!

You will enjoy first day benefits for Preventative and Basic Services and only a 12 month waiting period for major services. The waiting period is waived if you have had dental coverage for the previous 12 months with no more than a 60 day lapse in coverage.

The eye care plan is provided by Vision Service Plan (VSP). When visiting a VSP network doctor you will receive an annual eye exam, lenses, and frames provided once every 24 months after a minimal co-pay. Without VSP, you can expect to pay an average of \$87.81 for an eye exam, \$216.73 for single vision glasses, and \$253.51 for bifocal glasses. With VSP, you'll save!

Complete the enrollment form on the reverse side of this page to enroll in the dental and/or vision plans.



800.258.7041

ADVANTAGES OF DENTAL COVERAGE:

- Your routine cleanings and exams are covered at 100% of the usual and customary rate after the deductible (*twice per calendar year*)
- \$75 Calendar Year deductible per person
- \$1,500 Calendar year benefit per person
- Dental rewards may allow your \$1,500 calendar year benefit to grow to \$2,500
- NO referral required for specialty care

Plan Highlights:

- **Preventative Services: 100% coverage***
Oral exams, routine cleanings
- **Basic Services: 80% coverage***
Fillings, denture and crown repairs, x-rays, anesthesia, oral surgery (*simple & complex extractions*)
- **Major Services: 50% coverage***
Endodontics (root canals), periodontics (gum disease), crowns, dentures

Call 1.888.239.3336 or visit www.ameritasgroup.com/resources/find.asp for more information or to locate a provider.

**Reimbursement percentages are based on the usual and customary charges for services in your geographical area. Network providers may not be available in all states or geographic areas. All services are subject to limitations and exclusions. The master insurance policy providing coverage is governed by the laws of Washington.*

VISION PLAN HIGHLIGHTS:

- Exam covered in full once every 12 months

Prescription Glasses:

- Lenses covered in full once every 12 months
(*Progressive, single vision, lined bifocals, and lined trifocal lenses.*)

Frames Once Every 24 Months:

- Frame of your choice covered up to \$120
- Plus, 20% off any out-of-pocket costs
-OR-

Contact Lenses Once Every 12 Months:

When you choose contacts instead of glasses, your \$120.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts. If you choose contact lenses you will be eligible for a frame 12 months from the date the contact lenses were obtained. Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses.

Your Co-Pays:

- Exam: \$15.00 ■ Lenses: \$25.00 ■ Contacts: No co-pay

Call 1.800.877.7195 or visit www.vsp.com/go/wssra for more information or to locate a provider in your area.



WSSRA Group Dental & Vision Plan

Complete this form to enroll in the WSSRA Group Dental and/or Vision Plan.
Membership with WSSRA is required to enroll in these plans.
Underwritten by Ameritas Life Insurance Corp. Administered by AMBA.



ENROLLMENT INSTRUCTIONS: Refer to the payment instructions below for payment.
Complete this application and mail to: AMBA, 6034 W. Courtyard Dr., Ste. 300, Austin TX, 78730.

Washington State School Retirees' Association Member Information

Retired From:		Retirement Date:	
Member Name (Last, First)		Social Security Number (required)	
Mailing Address			
Home Phone	City	State	Zip
Date of Birth	Gender	Email Address:	

Have you had continuous dental coverage for the past 12 months with less than a 60 day gap in coverage?
 Yes No If Yes, Carrier Name: _____
 Effective Date: ___ / ___ / ___ Termination Date: ___ / ___ / ___

Monthly Dental Coverage Only: <input type="checkbox"/> Member (\$49.01) <input type="checkbox"/> Member + 1 (\$98.02) <input type="checkbox"/> Family (\$121.15) \$ _____
Monthly Vision Coverage Only: <input type="checkbox"/> Member (\$13.90) <input type="checkbox"/> Member + 1 (\$25.95) <input type="checkbox"/> Family (\$32.00) \$ _____
Monthly Dental + Vision Coverage: <input type="checkbox"/> Member (\$62.91) <input type="checkbox"/> Member + 1 (\$123.97) <input type="checkbox"/> Family (\$153.15) \$ _____
Total: Dental Premium + Vision Premium +\$20 One-Time Enrollment Fee \$ _____

Eligible Dependents to be Covered

Name	DOB	Gender	Student	Disabled	Social Security Number
Spouse					
Child					
Child					

Payment Method

Convenient Monthly Bank Payment: Make your check payable to AMBA for your first month's premium plus the \$20 enrollment fee and attach a VOIDED check. Deposit slips are not acceptable.
Authorization to honor drafts drawn by Association Member Benefits Advisors (AMBA). I hereby authorize you to initiate debit entries on my account. This authority is to remain in effect until revoked by me in writing and until AMBA receives such notice. I agree that AMBA shall be fully protected in honoring such debit. Non-payment of insurance premium(s) results in the forfeiture of insurance. NOTE: Bank drafts occur on the 2nd business day of each month.

 _____ Date _____
 Your signature EXACTLY as it appears on your Bank Records

Office use only: Effective Date: _____ ACH Date: _____ Entered: _____
 ID _____ MA _____ R _____