MSTA DENTAL AND VISION ENROLLMENT FORM FOR MEMBERS ONLY

Here's all you do to enroll:
1.) Complete the information below
2.) Select your plan(s) choice
3.) Choose your payment type
4.) Forms received by the 20th of a month will become effective the 1st of the following month

STEP 1: TELL US ABOUT YOURSELF

Name: Address:	**Gender:** ☐ Male ☐ Female	**Date of Birth:** ____ /____ /_____ MM DD YYYY	**Social Security Number** (Required)**:**

Phone Number: (_____) _____-_____	**Email Address:**	**I would like to receive Paperless correspondance and/or Renewal Invoices via email** ☐ Yes ☐ No

STEP 2: SELECT YOUR COVERAGE	**Dental**		**Vision**	
	1st MONTH RATE	ANNUAL RATE	1st MONTH RATE	ANNUAL RATE
Member	☐ $43.00	☐ $516.00	☐ $8.00	☐ $96.00
Member +1	☐ $78.50	☐ $942.00	☐ $15.00	☐ $180.00
Member +2	☐ $120.50	☐ $1446.00	☐ $23.00	☐ $276.00

STEP 3: SPOUSE OR DEPENDENT COVERAGE INFORMATION: Dependent children up to age 26 are eligible for coverage.

First Name: _____ **Last Name:** _____	**Gender:** ☐ Male ☐ Female	**Date of Birth:** ____ /____ /_____ MM DD YYYY	**Social Security #** (Required)**:**
First Name: _____ **Last Name:** _____	**Gender:** ☐ Male ☐ Female	**Date of Birth:** ____ /____ /_____ MM DD YYYY	**Social Security #** (Required)**:**

STEP 4: PAYMENT CHOICE: *(Please select one)*

I hereby apply for the coverage indicated, and understand that the premium payment is for 12 months of coverage and is not refundable for any reason. If I do not renew my contract at the end of the 12 months, I cannot re-enroll for 36 months. I further understand that my enrollment is subject to receipt of payment in the correct amount. If a check is returned for any reason, a $20.00 fee will be charged.

☐ **Convenient Monthly Bank Draft** –

Make your check payable to PISI for your first month's premium and complete account information.

Routing Number (9 digit): _ _ _ _ _ _ _ _ _ **Account Number:** _____

I (we) authorize and request PISI to initiate electronic debit entries to my (our) account indicated on this form in the financial institution named on this form ("BANK"). I (we) authorize and request BANK to honor the debit entries initiated by AMBA and debit these charges to that account. This authorization will remain in effect until all amounts owed related to the contract are paid in full, or until I (we) cancel this authorization. To cancel this monthly withdrawal I (we) must notify AMBA and BANK in writing 60 days in advance to give AMBA and BANK a reasonable opportunity to act. Cancellation of this electronic debit authorization does not cancel the terms of the Dental/Vision contract, I am agreeing to pay the full annual Dental/Vision premium. I understand that the funds will be withdrawn on the 10th day of each month and that it is my responsibility to ensure sufficient funds are in my account at that time. If the 10th of the month falls on a weekend or holiday, PISI will initiate a debit entry on the next business day. If more than 2 withdrawals in a 12 month period are denied for any reason I understand I risk cancellation of my Dental/Vision Benefits.

☐ **Annual Payment**: Please make your check payable to AMBA.

_____ _____
Please sign as acknowledgment of above **Date**

For office use only Eff Date: _____ Cust ID: _____ DW: _____ VW: _____