PARSE APPLICATION and DENTAL & VISION ENROLLMENT FORM

HOW TO APPLY - SEE REVERSE FOR ADDITIONAL ENROLLMENT INFORMATION

1.) Complete Steps 1-2 to join PARSE. If you are applying for Insurance, complete Steps 1 - 5. *Please print clearly.*
2.) Return the application in the enclosed postage-paid envelope.
3.) AMBA must receive your fully completed application and all required payments by the 20th of a month for your effective date to be the 1st of the following month. Failure to send required payments may delay your effective date.
4.) **Be sure to include: Payment for PARSE dues and payment for insurance (annual or 1st month)**

STEP 1: TELL US ABOUT YOURSELF

First and Last Name:

Address:

Gender ☐ Male ☐ Female

Date of Birth: / / MM DD YYYY

SSN (Required for insurance):

Phone:

Email:

STEP 2: PARSE MEMBERSHIP ENROLLMENT FORM: *(These plans are available to PARSE members only)*

Select One:
☐ **Chapter Member** *(Retiree or Active Employee)*
☐ **Associate Member** *(Non-Retiree, Spouse/ domestic partner of Retiree*)*
☐ **Member-at-Large** *(No Chapter Designation, Out-of-State)*

Year Retired: ______________
Former or Current Agency (where you worked for the state): ________________
Chapter Number (from below): ____________

☐ Member Only: My $20 check for membership is enclosed
☐ Member + Spouse: My $40 check for membership is enclosed *(Spouse or Domestic Partner must become a PARSE Member (Associate or Chapter, as appropriate) to be eligible for benefits)*

Signature ____________________ Date

Spouse Signature ____________________ Date

Make membership checks payable to PARSE. Chapter may be changed at any time upon member request. PARSE membership is valid from 1/1-12/31 of the current calendar year. Any new member application submitted in October through December of any year will be a PARSE member for the remainder of that year plus the following calendar year. This applies to new members only and does not apply to anyone previously a PARSE member.

1 - 10 Blair, Bedford, Huntington
1 - 20 Central Penn (Adams, Cumberland, Dauphin, Juanita, Mifflin, Perry,York)
1 - 25 Franklin
1 - 27 Fulton
1 - 30 Lancaster, Lebanon
1 - 40 Mt. Nittany (Centre, Clinton)
1 - 50 MUNS (Montour, Union, Northumberland, Snyder)
2 - 10 Endless Mts. (Bradford, Sullivan, Susquehanna, Lycoming, Tioga)
2 - 20 Lackawanna, Wyoming
2 - 30 Luzerne, Columbia
2 - 50 Schuylkill, Carbon
2 - 60 Wayne, Pike, Monroe
3 - 10 Erie
3 - 20 Jefferson, Clearfield
3 - 27 Crawford
3 - 30 McKean, Potter, Cameron, Elk
3 - 40 Venango, Clarion, Mercer
3 - 50 Barton Schuler (Warren, Forest)
4 - 10 Berks, Lehigh, Norththampton
4 - 30 Delaware, Chester
4 - 50 Montgomery
4 - 60 Philadephia, Bucks
5 - 10 Cambria, Somerset
5 - 20 Indiana, Armstrong
5 - 30 West SICO (Westmoreland, South Indiana)
5 - 40 West Penn (Allegheny, Beaver Butler, Fayette, Greene, Lawrence, Washington)
5 - 50 Laurel Highlands (Somerset)
6 - 20 Member-At-Large(No Chapter Affiliation, Out-of-State Members)

STEP 3: SELECT YOUR COVERAGE

	Dental		Standard Vision		Enhanced Vision	
	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL
Individual (Applicant only)	☐$41.75	☐$481.00	☐$6.24	☐$74.00	☐$7.50	☐ $90.00
Two-Party (Applicant + 1)	☐$77.50	☐$910.00	☐$10.99	☐$131.00	☐$13.50	☐ $162.00
Family (Applicant +2 or more)	☐$119.00	☐$1408.00	☐$15.87	☐$190.00	☐$20.87	☐ $250.00

STEP 4: 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
SSN (Required for insurance purposes):

First Name: ____________________
Last Name: ____________________
Gender ☐Male ☐Female
Date of Birth: / / MM DD YYYY
SSN (Required for insurance purposes):

STEP 5: 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. Dental monthly payment option includes a $20.00 processing fee.

☐ **Convenient Monthly Bank Draft** – REFER TO REVERSE FOR MONTHLY RATES.
INCLUDE A CHECK FOR THE MONTHLY RATE (ABOVE) MADE PAYABLE TO AMBA AND COMPLETE INFORMATION BELOW
Routing Number (9 digit): __ __ __ __ __ __ __ __ __ **Account Number:** ____________________
If you do not include the first month's payment with application, AMBA will debit the above account at the time your application is processed.
I (we) authorize and request AMBA 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 at time of my annual renewal. Cancellation of this electronic debit authorization does not cancel the terms of the contract, I am agreeing to pay the full annual 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, AMBA 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 Benefits.
☐ **Annual Payment:** Please make your check payable to AMBA.

Please sign as acknowledgement of above ____________________ **Date** ____________

FOR OFFICE USE: Eff Date:________ **Cust ID:**________ **DW:**________ **VW:**________ **APPID:**________

ENROLLMENT INFORMATION

1. If you are only becoming a PARSE member, complete Steps 1 and 2. For insurance enrollment, complete Steps 1-5 on this enrollment form.
2. Unmarried dependent children can be enrolled up to age 26. Disabled dependent children can be enrolled to any age.
3. Mail your completed Application and payment to AMBA at 3913 Hartzdale Drive Suite 1300 Camp Hill PA 17011. ***Applications must be received by the 20th of a month to become effective the 1st of the following month. Your coverage will run for a 12-month period from your effective date.**
4. You will receive identification information from United Concordia and/or Davis Vision. ID cards will be issued in the policyholder's name but can also be used by spouses/dependents on the plans.
5. Next year, you will receive a renewal notice from our office to continue coverage. If you've paid annually, an annual payment will be requested. If you've paid monthly, the payments will automatically continue unless you notify us of any change or cancellation requests at that time.
6. These benefits are available to fully paid members of PARSE. Membership must be maintained in order for you to access the dental/vision policies. Membership to PARSE is based on a calendar year.
7. If your coverage is lapsed or cancelled for any reason, you must wait 36 months to re-enroll.

If you have any questions on enrollment please contact AMBA at 1 (800) 382-1352

MONTHLY PAYMENT INFORMATION

DENTAL PREMIUMS

	First Month's Check	Eleven Monthly Withdrawals	Annual Totals
INDIVIDUAL	$41.75	$41.75	$501.00*
TWO PARTY	$77.50	$77.50	$930.00*
FAMILY	$119.00	$119.00	$1,428.00*

VISION PREMIUMS - STANDARD PLAN

	First Month's Check	Eleven Monthly Withdrawals	Annual Totals
INDIVIDUAL	$6.24	$6.16	$74.00
TWO PARTY	$10.99	$10.91	$131.00
FAMILY	$15.87	$15.83	$190.00

VISION PREMIUMS - ENHANCED PLAN

	First Month's Check	Eleven Monthly Withdrawals	Annual Totals
INDIVIDUAL	$7.50	$7.50	$90.00
TWO PARTY	$13.50	$13.50	$162.00
FAMILY	$20.87	$20.83	$250.00

*A $20 fee is charged to pay the dental premium monthly.This fee is already included in the above monthly rates. Figures shown are what will be deducted from your account.

If you are paying monthly, be sure to include one month's premium with the application. This payment will cover the first month of your insurance, automatic withdrawals will begin the following month (and continue the 10th of every month).

GUIDE TO PARSE MEMBER BENEFITS

LONG TERM CARE

AMBA will build a policy to match your needs. You select the daily benefit amount, elimination period, and benefit period which best suits your needs for care. The policy features include no prior hospital stay and no waiting period for pre-existing conditions.

MEDICARE SOLUTIONS

This plan offers the freedom of choice to select the doctors, hospitals, and clinics that members want, and they will never be canceled because of age or health.

CANCER, HEART & STROKE INSURANCE

Benefits paid directly to you. Members select the benefit level that best suits their needs.

Call 1 (800) 382-1352 for more information today!

LIFE INSURANCE

Members can have peace of mind knowing that their premiums are guaranteed never to increase and their coverage is guaranteed never to decrease.

MASA (AIR & GROUND AMBULANCE PLAN)

MASA is dedicated to providing life-saving emergency assistance from home or while traveling. The coverage is designed to protect members against catastrophic financial loss when emergencies arise

HOME HEALTH CARE

Offers you care provid ed at home or in a facility. Benefits can be customized to fit your needs and your budget. Short term care programs can provide the protection you are looking for at affordable costs. AMBA can build plan that meet your needs financially and give you peace of mind that you have programs in place that provide financial protection at the time of need.