ASSOCIATION MEMBER BENEFITS ADVISORS

SFFMA partners with AMBA to bring dental and vision coverage to members!

Great News! The State Firemen's and Fire Marshals' Association of Texas (SFFMA) has selected Association Member Benefits Advisors (AMBA) to provide group dental and vision coverage to members.

Enclosed you will find information concerning the endorsed plan. Please take a moment to review and hand out the information to your peers.

If you have any questions concerning the dental benefits, Ameritas (the dental insurer) can be reached at 1-888-239-3336. For vision benefits, VSP can be reached at 1-800-877-7195. Finally, if you have questions concerning enrollment contact AMBA at 1-800-258-7041.

We believe these plans are some of the best available today. They provide significant value to the members of SFFMA. Member's spouses and dependent children are also eligible for coverage. Apply today!

A Dental & Vision Plan with YOU in Mind!

Exclusively for SFFMA Members!

Dear SFFMA Member:

The State Firemen's and Fire Marshals' Association of Texas (SFFMA) has some great news for you - group dental and vision plans are now available! **These plans provide excellent value and superior coverage**. The only requirement to participate in one or both of these plans is your continued membership with SFFMA.

The SFFMA endorsed dental plan **enables you to visit any dentist you choose!** All members have first day access to preventative and basic services with only a 12-month waiting period for major services. This waiting period is waived for members coming off 12 continuous months of other dental insurance with less than a 60 day lapse. **In Texas, common procedures such as root canals, bridges, and crowns can cost $800 or more each!** However, with rich benefit levels this plan can help ease the financial burden of dental expenses.

The Vision Service Plan (VSP) provides you with access to a vast, nationwide network of ophthalmologists and optometrists. Without the VSP Plan, 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. However, with VSP your eye exam is fully covered after a $15.00 co-pay, and your prescription glasses are fully covered up to your allowances after a $25.00 co-pay.

For questions about dental coverage, or to locate a network dentist in your area, please contact Ameritas at 1.888.239.3336. You can also visit Ameritas online at www.ameritasgroup.com/resources/find.asp. To locate a Vision Service Plan (VSP) provider in your area, call 1.800.877.7195 or visit www.vsp.com/go/sffma.

To take advantage of this special opportunity, have your application postmarked by mid month and your coverage will become effective the first day of the next month.

Dental Plan Highlights

- Freedom to use your own dentist; NO network required!
- Network providers offer savings of to 20-30%
- Your routine cleanings and exams are covered at 100% of the usual and customary rate, once per 6 months!
- $75 Calendar Year deductible per person
- $1,500 Calendar Year Maximum per person
- Dental rewards – enables your $1500 calendar year max to grow to $2,500!
- Preventative Services: 100% coverage*
  - Oral Exams (1 per 6 months)
  - Prophylaxis (teeth cleanings covered one per 6 months)
- Basic Services: 80% coverage*
  - Fillings
  - X-Rays
  - Denture Repairs
  - Oral Surgery (simple extractions)
  - Perio-cleanings
- Major Services: 25% year 1 / 50% thereafter*
  - Endodontics (root canals)
  - Periodontics (gum disease)
  - General Anesthesia
  - Crowns & crown repairs
  - Dentures
- Orthodontia Services: 50% ($1,000 lifetime max per child)

Vision Plan Highlights

(co-pays apply)

Exam covered in full.....every 12 months

Prescription Glasses

Lenses covered in full.....every 12 months

- Single vision, lined bifocal, & lined trifocal lenses.

In addition, you can experience significant savings on lens options such as transitional lenses and progressive lenses.

Frames.....every 24 months

- Frame of your choice covered up to $ 120.00.
- Plus, 20% off any out-of-pocket costs.

- or -

Contact Lens Care.....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
Prescription Glasses.....$25.00
Contacts.....No co-pay applies

Locate a provider at: www.vsp.com/go/sffma
Vision Service Plan (VSP) 1.800.877.7195

The plan information presented is highlights only. Call 1-800-258-7041 for more detailed information.

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

SFFMA Group Dental & Vision Plan

Complete this form to enroll in the SFFMA Group Dental and/or Vision Plan. Membership with SFFMA is required to enroll in these plans.

Association Member Benefits Advisors

Mailing Instructions: Mail this application with your first month's premium, plus the 1 time $20 enrollment fee, and a voided check for your future monthly deductions to: **AMBA, 6034 W. Courtyard Dr., Ste. 300, Austin TX, 78730**

State Firemen's and Fire Marshals' Association of Texas Member Information

Member Name (Last, First)			**Social Security Number** (required)
Mailing Address			
City	**State**	**Zip**	**Home Phone**
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:
☐ **Member** ($28.92) ☐ **Member + 1** ($60.12) ☐ **Family** ($105.43) $ _____

Monthly Vision Coverage Only:
☐ **Member** ($9.90) ☐ **Member + 1** ($17.85) ☐ **Family** ($22.60) $ _____

Monthly Dental + Vision Coverage:
☐ **Member** ($38.82) ☐ **Member + 1** ($77.97) ☐ **Family** ($128.03) $ _____

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 *(choose one)*

☐ **Convenient Monthly Bank Payment Option:** 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 and I agree that the amount of this debit entry may be increased or decreased in the future. Non-payment of insurance premium(s) results in the forfeiture of insurance. NOTE: Bank drafts occur on the 2nd business day of each month.

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

☐ **Annual Billing**
Make your check payable to AMBA for your monthly premium(s) x 12 plus the $20 one-time enrollment fee.

Office use only: Effective Date: _____ ACH Date: _____ Entered: _____

ID_____ MA _____ R _____

SFFMA-NM-06/10

The master insurance policy providing coverage is governed by the laws of Texas.