Sandia Plan Enrollment/Authorization Form

BenefitSource

PHP-MA 1/24

PLEASE PRINT CLEARLY

Social Security Number	Date of Birth / /	Sex ☐ M ☐ F
Name: Last, First, Middle Initial		
Address: Street, City, State, Zip		
E-Mail Address		

Coverage Effective Date / /	Agent
Dental Office Selected	
Home Phone	Work Phone

Covered Dependents Name: Last, First, Middle Initial	Relationship	Sex	Date of Birth
		☐ M ☐ F	/ /
		☐ M ☐ F	/ /
		☐ M ☐ F	/ /
		☐ M ☐ F	/ /

Draft Authorization/Membership Agreement

Unless I have elected annual payment, I hereby authorize BenefitSource to charge my account each month the applicable membership fee to be credited to my account with BenefitSource. This authority is to remain in full force and effect until I notify BenefitSource in writing of its termination (My Bank is authorized to make corrections should any be necessary). I have read and understand the terms and conditions of this authorization. I hereby authorize the release of my dental records to BenefitSource for use in a quality review program.

Signature _____

Date _____

PLEASE CHOOSE YOUR PAYMENT OPTION

☐ **Annual Payment** *Please check one:* ☐ **Check** ☐ **VISA** ☐ **MasterCard** ☐ **Discover**

Credit Card # _____

Expiration Date _____ CVV # _____

☐ **Monthly Bank Draft: Surepay Electronic Funds Transfer Payment**

Please charge my account monthly: ☐ **Checking** ☐ **Savings**

Routing # _____ Account # _____