# Sandia Plan Enrollment/Authorization Form

**PLEASE PRINT CLEARLY**

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

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

PHP-MA 2024

| Coverage Effective Date / / | Agent |
|---|---|

**Payment Authorization/Membership Agreement**

*I hereby authorize the BenefitSource plan administrator, EMI Health to charge my account each month, or annually, the applicable membership fee. This authority is to remain in full force and effect until I notify BenefitSource or EMI Health in writing of its termination (My Bank is authorized to make adjustments should any be necessary). I am aware "EMI Health" will appear on my bank statement for this transaction. I have read and understand the terms and conditions of this authorization.*

Signature _____

Date _____

**PLEASE COMPLETE PAYMENT OPTION**

☐ **Payment** *(choose one option)* ☐ **Annual Payment** ☐ **Monthly Payment (EFT)**

**Payment Method:** ☐ Check ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover ☐ EFT Checking ☐ EFT Savings

Credit Card # _____ Expiration Date _____ CVV # _____

EFT Payment Routing # _____ Account # _____