Sandia Plan Enrollment/Authorization Form

2024

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	/ /

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 # ______________________