

Instructions

Complete the enrollment/authorization form and include payment.



Mail to our Sandia Plan Administrator:

Sandia Plan
Attn: Beta Health Payment Processing
6465 Greenway Plaza Blvd., Suite 900
Centennial, CO 80111

Or:

If paying annually, with a credit card, complete and scan the Enrollment/Authorization Form and email to: sandiaplan@betadental.com

Enrollment forms received by the 20th of the month will become effective the first of the following month

Payment Options:

Annual Payment – payment may be made by check, Visa, MasterCard, American Express, or Discover cards. Make checks payable to: Beta Health (the Sandia Plan Administrator).

Monthly Payment – monthly payments may be made by electronic fund transfer (EFT) payment. Indicate this election on the Enrollment/Authorization Form. Include a check payable to Beta Health for the first month's payment or indicate the credit information wanted for the first month's payment. Each month the Membership Fee is automatically drafted on the first of the plan month for that month's membership. "Beta Health" will appear on the bank statements for this transaction.

Sign and date the Enrollment/Authorization Agreement.

Membership automatically renews year to year unless the membership is terminated in writing.

Sandia Plan Enrollment/Authorization Form



PLEASE PRINT CLEARLY

| | | | | | | | | | |
|---|--|----------------------|--|--|--|--------------------------------|--|--|--|
| Social Security Number | | Date of Birth / / | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | | PHP-MA 2024 | | | |
| Name: Last, First, Middle Initial | | | | | | Coverage Effective Date / / | | Agent | |
| Address: Street, City, State, Zip | | | | | | | | | |
| Phone | | Work Phone | | E-Mail Address | | | | | |
| Covered Dependents Name: Last, First, Middle Initial | | | | Relationship | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth / / | | Payment Authorization/Membership Agreement <i>I hereby authorize the BenefitSource plan administrator, Beta 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 Beta Health in writing of its termination (My Bank is authorized to make adjustments should any be necessary). I am aware "Beta Health" will appear on my bank statement for this transaction. I have read and understand the terms and conditions of this authorization.</i> | |
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | / / | | | |
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | / / | | | |
| | | | | | <input type="checkbox"/> M <input type="checkbox"/> F | / / | | | |
| | | | | | | | | Signature _____ | |
| | | | | | | | | Date _____ | |

PLEASE COMPLETE PAYMENT OPTION

Payment (choose option) Annual Payment \$61.20 Monthly Payment (EFT) \$5.10

Payment Method Check VISA MasterCard American Express Discover EFT Checking EFT Savings

Credit Card # _____ Expiration Date _____ CVV # _____

EFT Payment Routing # _____ Account # _____