Instructions

Complete the enrollment/authorization form and include payment.

BenefitSource

2024

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 months' 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

BenefitSource

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	

Coverage Effective Date / /	Agent

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

Payment Authorization/Membership Agreement

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.

Signature _____

Date _____

PLEASE COMPLETE PAYMENT OPTION

Payment *(choose option)* ☐ **Annual Payment** ☐ $88.00 (Ind) ☐ $149.00 (Ind+1) ☐ $212.00 (Ind+Fam) ☐ **Monthly Payment (EFT)** ☐ $7.85 (Ind) ☐ $12.75 (Ind+1) ☐ $18.25 (Ind+Fam)

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

Credit Card # _____ Expiration Date _____ CVV # _____

EFT Payment Routing # _____ Account # _____