Federal Employee DENTAL Enrollment/Authorization Form

for **Presbyterian Health Plan** Members

BenefitSource

PLEASE PRINT CLEARLY

Social Security Number	Coverage Effective Date / /	Date Employed Full Time / /	Dental Office Selected ***Option 1 only***
Name: Last, First, Middle Initial		Date of Birth / /	Sex ☐ M ☐ F
Home Address: Street, City, State, Zip			
Home Phone	Work Phone	E-Mail Address	
Do you have other dental coverage? ☐ YES ☐ NO	Do any of your dependents have other coverage? ☐ YES ☐ NO ***If YES, list Carrier below.***		

	Spouse Name: Last, First, Middle Initial	Sex ☐ M ☐ F	Date of Birth / /	Name of Other Carrier
CHILDREN	1.	☐ M ☐ F	/ /	
	2.	☐ M ☐ F	/ /	
	3.	☐ M ☐ F	/ /	
	4.	☐ M ☐ F	/ /	
	5.	☐ M ☐ F	/ /	
	6.	☐ M ☐ F	/ /	

PLEASE CHOOSE YOUR PLAN AND PAYMENT OPTIONS

☐ Option 1: Sandia Plan

Monthly Bank Draft

To initiate this Bank Draft Option, please include the first month's payment.

☐ **$6.50** ☐ **$11.25** ☐ **$16.50**

Annual Premium

☐ **$69.00** ☐ **$127.00** ☐ **$184.00**

☐ Option 2: Elite Plan

Monthly Bank Draft

To initiate this Bank Draft Option, please include the first month's payment.

☐ **$29.14** ☐ **$56.30** ☐ **$94.66**

☐ Option 3: PPO Dental Plan

Monthly Bank Draft

To initiate this Bank Draft Option, please include the first month's payment.

☐ **$29.28** ☐ **$56.42** ☐ **$99.18**

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 # _____

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.

X _____

Dentist Nomination Form

If the dentist of your choice is not listed in this directory, you may complete this form to nominate the dentist to participate in the BenefitSource Dental Network. An application packet will be sent to eligible providers. The normal time frame for credentialing of dentists takes approximately 60 days after this application has been received.

Dentist: Name _____

City _____

Member: Name _____

Please return completed form to **BenefitSource, Inc.**, Attn: Provider Services

MAIL 1804 Juan Tabo NE, Suite A, Albuquerque, NM 87112 | **FAX** 505 237 8344 | www.benefitsource.org

Thank you for your interest in the BenefitSource Dental Network

2017

Federal Employee VISION Enrollment/Authorization Form

for **Presbyterian Health Plan** Members

BenefitSource

PLEASE PRINT CLEARLY

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

COMPLETE FOR DEPENDENT COVERAGE

	Spouse Name: Last, First, Middle Initial	Sex ☐ M ☐ F	Date of Birth / /	Name of Other Carrier
CHILDREN	1.	☐ M ☐ F	/ /	
	2.	☐ M ☐ F	/ /	
	3.	☐ M ☐ F	/ /	
	4.	☐ M ☐ F	/ /	
	5.	☐ M ☐ F	/ /	
	6.	☐ M ☐ F	/ /	

PLEASE CHOOSE YOUR PLAN AND PAYMENT OPTIONS

Monthly Bank Draft Options

To initiate this Bank Draft Option, please include the first month's payment.

PHP High Option Materials Buy-up Option

☐ **$7.98** ☐ **$12.64** ☐ **$14.56** ☐ **$24.62**

PHP Standard Plan

☐ **$9.98** ☐ **$15.98** ☐ **$18.42** ☐ **$31.54**

Monthly Bank Draft: Surepay Electronic Funds Transfer Payment

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

Routing # _____

Account # _____

Draft Authorization/BenefitSource, Inc. Member 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 Vision Care Direct. 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 agree to maintain coverage for a period of one year. Less than one year of coverage may result in my being billed usual and customary rates minus membership fees paid. All membership fees are non-refundable.

X _____

Vision Practitioner Nomination Form

If the Vision Practitioner of your choice is not listed in our provider network, please fill out the nomination form below. An application packet will be sent to eligible providers. The normal time frame for credentialing takes approximately 60 days after this application has been received.

Practitioner: Name _____

City _____

Member: Name _____

Please return completed form to **BenefitSource, Inc.**, Attn: Provider Services

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2017