

Sandia Plan Enrollment/Authorization Form



PLEASE PRINT CLEARLY

1/20

Social Security Number		Date of Birth / /		Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Name: Last, First, Middle Initial				Coverage Effective Date / /	Agent	
Address: Street, City, State, Zip				Dental Office Selected		
E-Mail Address				Home Phone	Work Phone	
Covered Dependents Name: Last, First, Middle Initial	Relationship	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Draft Authorization/Membership Agreement <i>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.</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	/ /			
PLEASE CHOOSE YOUR PAYMENT OPTION				Signature _____	Date _____	

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 # _____