

SCREEN ACTORS GUILD - PRODUCERS HEALTH PLANS

Self-Pay Program Enrollment Form - Plan I

Complete this form and return it to the Plan Office no later than 60 days from the date coverage terminates. Enrollment forms not received during this period will be considered as a rejection of coverage. You will not be permitted to elect coverage at a later date.

Participant Information

Soc. Sec. No. _____ Name _____

Billing Address _____

City _____ State _____ Zip _____ Phone # _____

I have read the Self-Pay Program Summary and I understand the terms and conditions of this continued coverage.

Date _____ Participant's Signature _____

Election of Coverage

If you elect “**BASIC**” coverage, one premium will cover you and all eligible dependents (spouse and children). The Lower Cost Option excludes dependent coverage. Your election cannot be changed except under the conditions described in your Self-Pay Program Summary. Certain dependents have the right to enroll for the “**BASIC**” coverage individually if the participant does not enroll. If your family members want to make a separate election, please contact the Managed Care Department. Family members are subject to the same enrollment period as the participant.

*Please check the type of coverage you want. Your premium rates are in your Notice of Termination.
Please check only one box.*

Self-Pay Options	Medical and Dental
Plan I BASIC – Family coverage	<input type="checkbox"/> \$ 885.00 monthly \$ 2,655.00 quarterly
Lower Cost Option – Individual coverage	<input type="checkbox"/> \$ 460.00 monthly \$ 1,380.00 quarterly

First Premium Payment

Your first payment is due on the first day of the month immediately following the date on which your Earned Eligibility terminates. You must pay your first premium payment within 45 days of the end of your enrollment period. Claims submitted before we receive your premium payment cannot be considered. Also, coverage will not be verified for any health provider prior to the receipt of your premium payment. **Please refer to the chart on the back for the Plan's additional premium payment options.**

Your first payment must include all of the premiums to keep your coverage continuous from the date your Earned Eligibility terminated. For example, if your Earned Eligibility ended on December 31, and you make your first premium payment in February, you must pay for both January and February.

Make your check or money order payable to **Screen Actors Guild - Producers Health Plan** and include your social security number. Mail your check with your enrollment form.

(Application MUST be complete)

SAG-Producers Health Plan * P. O. Box 7830 * Burbank, CA 91510-7830
(800) 777-4013 (this excludes the Los Angeles area) * (818) 954-9400

(SP PI 09w)

SELF-PAY PAYMENT OPTIONS

Self-Pay premium due date: 1st of each calendar month

	DESCRIPTION	PAYMENT SET-UP	COUPONS	PARTICIPANT'S MONTHLY RESPONSIBILITY
PAY BY WEB	<ul style="list-style-type: none"> ▪ Allows you to pay online with a credit card. ▪ You may pay some or all of the yearly premium at one time. ▪ You receive instant confirmation that your payment has been received. ▪ Payments are nonrecurring Plan does not automatically charge your credit card every time a payment is due. 	None. Simply visit www.sagph.org and click on "Pay Health Premium."	You will receive annual coupons in advance.	Visit www.sagph.org before the premium due date, click on "Pay Health Premium" and enter credit card information.
PAY BY PHONE	<ul style="list-style-type: none"> ▪ Allows you to pay over the telephone with a credit card. ▪ You may pay some or all of the yearly premium at one time. ▪ You receive instant confirmation that your payment has been received. ▪ Payments are nonrecurring – Plan does not store your credit card information and charge your card every time payment is due. 	None	You will receive annual coupons in advance.	Call the Plan Office (818) 954-9400 (outside the Los Angeles area (800) 777-4013 before the premium due date to access the Automated Information Center and follow the prompts.
CHECKING AND SAVINGS AUTOMATIC PAYMENT PLAN	<ul style="list-style-type: none"> ▪ Automatic recurring deduction from a checking or savings account. ▪ Payments are deducted on the 25th of the month before the due date. (e.g. December 25th for January premium) ▪ Applies to US banks only. 	Complete Application and return to Plan Office no later than 45 days before premium due date. (e.g. November 15 th for January premium)	You will not receive annual coupons in advance.	None – Payments are automatically deducted from your checking or savings account.
PAY BY CHECK	<ul style="list-style-type: none"> ▪ You mail your monthly premium check directly to the Plan Office. ▪ Your cancelled check is your receipt of payment. ▪ Applies to US banks only. 	None	You will receive annual coupons in advance.	Mail check far enough before the premium due date to the Plan Office. Premiums must be <u>received</u> by premium due date