

SCREEN ACTORS GUILD - PRODUCERS HEALTH PLANS

Self-Pay Program Enrollment Form – for Qualified Dependents - Plan II – Medical and Dental

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 _____

Applicant 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 _____ Applicant'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 only one box below

Self-Pay Options	Medical and Dental
Plan II BASIC – Family coverage	<input type="checkbox"/> \$ 764.00 monthly \$ 2,292.00 quarterly
Lower Cost Option – Individual coverage	<input type="checkbox"/> \$ 470.00 monthly \$ 1,410.00 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
(818) 954-9400 or (800) 777-4013**

(SP PIIMD Q11w)