SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN

3601 WEST OLIVE AVENUE, BURBANK, CA 91505 MAILING ADDRESS: P.O. BOX 7830, BURBANK, CA 91510-7830
(818) 954-9400 or (800) 777-4013 FAX (818) 953-9880
email: psd@sagph.org website: www.sagph.org

SELF-PAY ENROLLMENT FORM

To enroll in the Self-Pay Program return this form to the Plan no later than 60 days from the later of: the date your coverage terminated or the date on your self-pay enrollment offer. Enrollment forms must be received within the above stated period. Self-pay coverage will only be extended when your enrollment is completed and payment is received.

Participant Information:

NAME	DATE OF BIRTH	SOCIAL SECURITY OR PLAN HCID NUMBER

ADDRESS	PHONE NUMBER

Elect one tier rate within your chosen Plan:

MONTHLY RATES

PLAN I

INDIVIDUAL ONLY ☐ $624.00
INDIVIDUAL PLUS 1 DEPENDENT ☐ $1,225.00
INDIVIDUAL PLUS 2 OR MORE DEPENDENTS ☐ $1,705.00

PLAN II WITH DENTAL*

INDIVIDUAL ONLY ☐ $539.00
INDIVIDUAL PLUS 1 DEPENDENT ☐ $1,058.00
INDIVIDUAL PLUS 2 OR MORE DEPENDENTS ☐ $1,472.00

*Mental health and substance abuse not covered.

List your eligible dependent(s) you wish to enroll in the Self-Pay Program and complete the signature section:

FIRST & LAST NAME	**GENDER** (M/F)	**DATE OF BIRTH** MM/DD/YYYY	**SSN**	**Indicate relation: spouse, natural, adoptive or foster parent or legal guardian**

Important Note: Eligible dependents may include a spouse or child under the age of 26. You may be required to submit supporting dependent proof documentation, such as a marriage certificate, birth certificate, adoption or guardianship papers.

I hereby agree to the terms and conditions of the Self-Pay Program:

DATE:	PARTICIPANT SIGNATURE:
EMAIL ADDRESS:	