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

Loss of Dependent Status

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	SOCIAL SECURITY OR PLAN HCID NUMBER

Applicant Information:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS		PHONE NUMBER

Elect the appropriate tier rate.

MONTHLY PLAN II WITH DENTAL RATES*

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

(SP 11-2015w)