Health Insurance Enrollment Form

sanabenefits.com (833) 726-2123 sa•na

Employee Profile

First Name | Last Name | Date of Birth (MM/DD/YYYY) | Social Security Number (SSN)

Legal Sex (M F) | Email or Employee ID | Phone Number ( ) | Date of Hire (MM/DD/YYYY)

Home Address

Street | Apartment/Unit

City | State | Zip Code

Select Your Plans

Choose 1 from each available coverage type. Rates displayed reflect monthly cost.

MEDICAL	☐ Plan P15	☐	☐	☐	☐
Employee Only	$384.12				
Employee + Spouse	$843.03				
Employee + Child(ren)	$728.29				
Employee + Family	$1225.43				

Waive Medical Coverage

To opt out of Medical coverage, select how you will be covered:

- ☐ From my Spouse or Partner
- ☐ Medicare
- ☐ COBRA
- ☐ From my Parent
- ☐ Other
  please submit an explanation

DENTAL	☐ SmartPremium Plus 100/80/50-1500-MAC	☐
Employee Only	$29.50	
Employee + Spouse	$59.01	
Employee + Child(ren)	$61.95	
Employee + Family	$91.25	

Waive Dental Coverage

☐ I do not want to enroll in any dental insurance plan offered by my employer.

No Dental Available

☐ If this is selected there is no dental benefit available to you through your employer.

VISION	☐ VSP Choice Plan #2	☐
Employee Only	$9.00	
Employee + Spouse	$18.00	
Employee + Child(ren)	$15.62	
Employee + Family	$24.62	

Waive Vision Coverage

☐ I do not want to enroll in any vision insurance plan offered by my employer.

No Vision Available

☐ If this is selected there is no vision benefit available to you through your employer.

Don't forget page 2!

Dependent: Spouse or Domestic Partner

First Name

Last Name

Date of Birth (MM/DD/YYYY) / /

Social Security Number (SSN) – –

Legal Sex M F

My spouse or partner lives at my address

Address (Street, City, State, ZIP) – Required if dependent does not live at your address

Select the coverage your Spouse or Partner should be enrolled in.

- Medical
- Dental
- Vision

Dependent: Child

First Name

Last Name

Date of Birth (MM/DD/YYYY) / /

Social Security Number (SSN) – –

Legal Sex M F

This child lives at my address

Address (Street, City, State, ZIP) – Required if dependent does not live at your address

Select the coverage this child should be enrolled in.

- Medical
- Dental
- Vision

Dependent: Child

First Name

Last Name

Date of Birth (MM/DD/YYYY) / /

Social Security Number (SSN) – –

Legal Sex M F

This child lives at my address

Address (Street, City, State, ZIP) – Required if dependent does not live at your address

Select the coverage this child should be enrolled in.

- Medical
- Dental
- Vision

Dependent: Child

First Name

Last Name

Date of Birth (MM/DD/YYYY) / /

Social Security Number (SSN) – –

Legal Sex M F

This child lives at my address

Address (Street, City, State, ZIP) – Required if dependent does not live at your address

Select the coverage this child should be enrolled in.

- Medical
- Dental
- Vision

I certify that the information in this form is true and correct. I understand that any false information in this document may affect my eligibility and may disqualify myself and/or my dependents in any of the plans offered by Sana Benefits Inc. and/or its affiliates or affiliated providers. I also understand that, by declining coverage, I and/or my dependents voluntarily waive our rights to participate in employer-sponsored dental plans listed above.

Employee Signature **Date**