

IMPORTANT INFORMATION/INSTRUCTIONS

Spouses of Participants of the Motion Picture Industry Health Plan are required to enroll in their employer's insurance, even if they must pay all or a portion of the premium cost for coverage. The Participant's spouse is required only to take the medical/hospital benefit.

Spouses must enroll in their employer's group health insurance as soon as it is available. The Plan will not pay any claims for a period in which the spouse was entitled or eligible to enroll in their employer's group health insurance.

Eligibility and Coordination of Benefits for Dependent children

If your spouse or domestic partner enrolls in his or her employer's health insurance and the dependent children can be enrolled in that plan free of charge, the children must be enrolled in that plan. If there is a premium for the children, or if the spouse or Domestic Partner's birth date is later in the year than the Participant's birth date, the dependent children may continue to be enrolled in the MPI Health Plan. (MPIHP uses birth dates to determine primary and secondary coverage.) If they are not enrolled under these circumstance the MPI health Plan will provide no benefit coverage for your dependent child(ren).

If the spouse misses the open enrollment date and is not able to enroll until the next open enrollment, the MPI Health Plan will cancel all of the spouse's benefits including, Dental, Vision and Prescriptions until the spouse is enrolled in his/her employer's group insurance.

Form 2, must be completed by the spouse's employer representative and must be signed by the spouse and the Participant before it is returned to the Plan office. Forms that are not completed in full or incorrect will be returned to the Participant.

It is the Participant's responsibility to notify the MPI Health Plan Eligibility Department of any changes in their spouse's group insurance or employment status. Failure to notify the Plan office will result in a delay or denial of the spouse's claims and/or Eligibility.

Retirees

If your spouse is receiving retirement health insurance through a former employer, please complete FORM 1 and FORM 2 and indicate all the insurance information. You do not need to submit this form to your former employer.

If you are MEDICARE-eligible, please also indicate the effective date.

It is important that you and your dependent(s) enroll in both Medicare Part A and B because at age 65, Medicare will become your primary coverage.

Disabled Participants and/or Spouses

When you or your spouse become eligible for Medicare benefits, due to a disability or due to reaching age 65, you must enroll at your Social Security Administration (SSA) office for Medicare "Part B" benefits.

In cases of Disability, you usually become eligible for Medicare two years after your Entitlement date (this is not the date that you receive your first payment, this is 5 months after SSA has found you to be disabled). However, in certain cases, you might become eligible for Medicare before the two-year period.

In any circumstance, **you must enroll in Medicare Part B at the time you become eligible. If you have not received this information, please contact your local Social Security office.**



**EMPLOYER / GROUP
SPOUSE COORDINATION OF BENEFITS
QUESTIONNAIRE**

FORM 2

EMPLOYER INFORMATION
TO BE COMPLETED BY THE EMPLOYER *(please print)*

Employee Name:		Social Security Number:	
Employer Name:			
Address:			
City:	State:	ZIP:	Phone:

DO YOU OFFER EMPLOYER GROUP HEALTH INSURANCE TO THIS EMPLOYEE?

- No** If NO, **STOP**; Sign below and return original form to Employee
 Yes If enrolled, what is the initial effective Date of Group Health Insurance:

If not enrolled, what is the next open enrollment & effective date?	Enrollment date:	Effective date:
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Is a premium required for Group Insurance for Children Yes No

Please list names of all family members enrolled:	Effective Date

EMPLOYER INSURANCE INFORMATION
TO BE COMPLETED BY THE EMPLOYER *(please print)*

Group Health Plan Name:			
Address:			
City:	State:	ZIP:	Phone:
Group Identification Number:		Policy Number:	

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT

Authorized Employer Signature [required]	Title [required]	Telephone Number	Date

RETURN ORIGINAL FORM TO EMPLOYEE

PARTICIPANT STATEMENT

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT, and I understand that, to ensure that benefits are coordinated properly, MPIHP will verify the accuracy of information by conducting audits, contacting me, my spouse's employer, and/or insurance plan. It is fraudulent to knowingly fill out this form with any information that is false.

Employee (Spouse) Signature [required]	Date [required]	(Area Code) Phone Number
Participant Signature [required]	Date [required]	(Area Code) Phone Number

IF ANY INFORMATION ON THIS FORM CHANGES, A NEW FORM MUST BE SUBMITTED WITHIN 30 DAYS

Questions, call: 818 or 310.769.0007 Ext 263 / Outside So. Calif: 1 888.369.2007 Ext 263, or E-mail: eligibility@mpihp.org