MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

Active Health Plan

APPLICATION FOR COVERAGE
Adopted child, Foster child, Stepchild, or child for whom you are the legal guardian

The undersigned Participant declares:

1. That_____ , _____ , (the "Child") is:
[Name of Child] [SS# of Child]

[Check one]

- ☐ Stepchild
- ☐ Foster child
- ☐ Legally adopted child, or child who has been placed with me for adoption
- ☐ Child required to be recognized under a Qualified Medical Child Support Order
- ☐ Child for whom I am the legal guardian

2. That the Child has not reached his/her 26th birthday.

3. That each of the following documents has been provided to MPI:

   a. Beneficiary/Enrollment Form

   b. Child's birth certificate/birth record

   c. Legal documentation (or other documentation deemed adequate by MPI) stipulating legal guardianship, foster parenthood, adoption or placement for adoption

   d. Other insurance information

4. That no coverage will be provided for the Child until the required documentation has been received by MPI.

I declare under penalty of perjury under the laws of the State of California that the foregoing statements are true and correct.

_____	_____	_____
Participant's Signature	Participant's Social Security #	Date

042017