

Requirements For Adding Dependents To Your Health Insurance

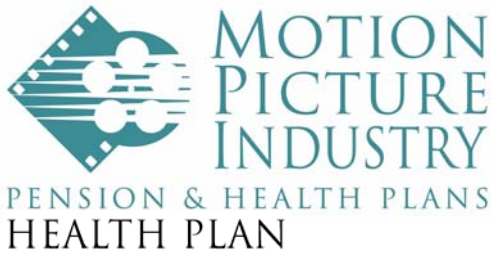
In addition to completing a new Beneficiary/Enrollment card, application must be made by the Participant to determine eligibility for **all** dependent family members. The documentation listed in the table below is *required* to make this determination.

If You Want To:	Provide The Following Documentation:
Add your biological dependent child.	Copy of birth certificate.
Add a foster child, stepchild or adopted child, or a child for whom you are the legal guardian.	Copies of birth certificate, legal documentation and application. (See reverse.)
Add a new dependent spouse.	Copy of marriage certificate. *Coordination of Benefits Questionnaire.
Remove a divorced spouse.	Copy of Final divorce decree.
Add or change a beneficiary.	None.
Add dependents age 19 or older.	In order for a non-biological child to qualify as an eligible dependent, the child must be unmarried, under age 19 (unless such child meets the student Eligibility requirements), live with you in a parent-child relationship and be dependent upon you for support and maintenance. Documentation must be provided to the Plan as indicated above.

Please be aware that ***claims will not be paid*** for any new dependent unless the Plan Office has received **all** required enrollment forms and documents. [**Note:** Social Security numbers are required on the form for yourself and all dependents. Social Security numbers for newborns should be submitted to the Plan as soon as available.]

* The Coordination of Benefits questionnaire **ONLY** applies to Participants and their dependents enrolling in the Blue Shield of California/Motion Picture Industry Health Plan or the National Blue Cross/Blue Shield PPO Plan.

ELIGIBILITY DEPARTMENT



Application for Coverage Non-Biological Dependent Child

The undersigned Participant represents and agrees:

1. That _____, SSN: _____, (the "Child) is:
(Name of Child) (SS# of Child)

Check One

- A stepchild
- A foster child
- A legally adopted child, or child who has been placed with the Participant for adoption
- A child required to be recognized under a Qualified Medical Child Support Order
- A child for whom the Participant is legal guardian

2. That the Child is unmarried, lives with the Participant in a parent/child relationship and is dependent upon the Participant for support and maintenance.

3. That the Child:

Check One

- Has not reached his/her 19th birthday, OR
- Has not reached his/her 23rd birthday, is dependent upon the Participant for full support and is a full-time student in an accredited school or college (Additional student documentation as required by the Plan will be or has been provided.)

4. That each of the following documents has been provided to the Plan:

- A completed Beneficiary/Enrollment Card
- The Child's Birth Certificate
- Legal documentation (or other documentation deemed adequate by the Plan) stipulating legal guardianship, foster parenthood, adoption or placement for adoption

5. That no coverage will be provided for the Child until the required documentation has been received by the Plan office and a Notice of Coverage has been issued by the Plan office to the Participant attesting to the eligibility of the Child.

6. That, if the Participant fails to provide the above-referenced documentation and the Plan pays a claim for the Child, the Participant will be held personally responsible for any and all over-payments. The amount of any such payment may be deducted from benefits to which the Participant would otherwise be entitled.

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 SSN Date

Motion Picture Industry Health Plan Beneficiary/Enrollment Card

Information submitted by you to the Plan Office will be used to update records at the MPI Pension, IAP and Health Plans.

This card is used to enroll you and your dependents and to designate the beneficiary(ies) of your life insurance. Benefit cards will not be issued and claims will not be paid until your Beneficiary/Enrollment card is received in the Plan office. Please note that ***this card must be completed in full and signed by the Participant*** before it will be accepted as a valid record.

Social Security Number	Last Name	First Name	Middle	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male
Mailing Address		City	State	ZIP Code	Daytime Phone Number ()
Marital Status (Check One): <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Same-Sex Domestic Partnership		Date of Marriage	Date of Divorce	Spouse Date of Death	SOCIAL SECURITY NUMBERS FOR ALL DEPENDENTS <u>MUST BE PROVIDED</u>

LIST ALL OF YOUR ELIGIBLE DEPENDENTS IN THE SPACES PROVIDED BELOW. CONSULT YOUR SUMMARY PLAN DESCRIPTION FOR THE DOCUMENTS REQUIRED TO DETERMINE ELIGIBILITY FOR DEPENDENTS.

Last Name of Spouse or Same-Sex Partner	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number
Your Biological Children Under 19 Years of Age				
Last Name	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number
Last Name	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number
Last Name	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number
Last Name	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number
Last Name	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number
Your Non-Biological Children Under 19 Years of Age				
Last Name	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number
Last Name	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number
Your Children Between 19 and 23 Years of Age				
Last Name	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number
Last Name	First Name & M.I.	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number

The next section relates to the life insurance portion of your benefits and should be completed carefully. Please be aware that unless your spouse or same-sex partner is also listed below, s/he will not be considered your designated beneficiary. Your beneficiary must claim the life insurance within two years of your date of death in order to be eligible for the life insurance benefit. If your beneficiary does not make a claim within this two-year period, the benefit shall be irrevocably forfeited and contributed to the Motion Picture and Television Fund.

Designate your Beneficiaries in the spaces provided below, in order of preference. If the benefit is to be shared ("Joint"), please specify. NOTE: If you check "Yes," the benefit will be divided equally. If you check "No," the first listed beneficiary will be the only one paid.				
Last Name	First Name	Middle Name	Relationship	Age
Mailing Address				Joint <input type="checkbox"/> Yes <input type="checkbox"/> No
List your contingent or joint Beneficiary below. If the benefit is to be shared ("Joint"), please specify. If there is no other person you wish to designate, you may list the Motion Picture & Television Fund or any other charitable organization. If additional space is needed, you may attach a separate piece of paper.				
Last Name	First Name	Middle Name	Relationship	Age
Mailing Address				Joint <input type="checkbox"/> Yes <input type="checkbox"/> No

I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge all information provided on this document is true, correct and complete.

Signature of Participant Required	Date	Union or Guild
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