MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

Mailing Address:
P.O. Box 1999 • Studio City, California 91614-0999
855 ASK-4MPI (855 275-4674)
FAX: 818.766.1229 • EMAIL: service@mpiphp.org

Benefit Selection Form

Information provided on this form will be used to update the records of the MPI Pension, IAP and Health Plans

1. PARTICIPANT'S INFORMATION

Social Security/ MPI ID Number	Last Name	First Name	M.I.	Birth Date	Gender (Circle One) Male Female
Home Address	City	State	Zip	Marital Status (Circle One) Single Married Divorced	Day Phone
Home E-Mail	Alternative E-Mail			Mobile Phone	Home Fax

2. PARTICIPANT AND FAMILY INFORMATION. LIST ALL ELIGIBLE DEPENDENTS TO BE ENROLLED IN THE PLANS SELECTED BELOW

STATUS CODES: SP - Spouse **CH** - Biological Child **FC** - Foster Child **AD** - Adopted Child **LG** - Legal Guardianship **SA** - Step Child **ST** - Student (Age 19-23) **HN** - Disabled (Over Age19) **C2** - Adult Dependent (Over Age 19)

Copies of birth certificates, marriage certificates, and/or other forms of documentation (dependent applications, divorce/custody documents) are required to enroll dependents.

If you choose HEALTH NET or OXFORD and an Independent Practice Association (IPA), use your Provider Directory to choose a Primary Care Physician for you and your dependents. You may choose a different physician for each member of your family. If you fail to list a Primary Physician, HEALTH NET or OXFORD will assign one to you.

Participant & Family Information		Incorrect information may result in non-payment of claims.			Status	HEALTH NET or OXFORD PRIMARY CARE PHYSICIAN	
Last Name (Self)	First Name	**Birth Date Mo/Day/Yr**	**Gender** (Circle One)	**Social Security Number (Required)**	**See Codes Above**	Name of Primary Care Physician ***ONLY*** if you selected an IPA above	Physician / Facility Number
Last Name (Spouse)	First Name		M F				
Last Name (Child)	First Name		M F				
Last Name (Child)	First Name		M F				
Last Name (Child)	First Name		M F				
Last Name (Child)	First Name		M F				
Last Name (Child)	First Name		M F				

3. OTHER GROUP INSURANCE PLAN

Do you or any family members have other *group* medical insurance? Yes No

If yes, please print the information about your other group insurance plan in the spaces below

Last Name, First Name:	Effective Date:	Policy Number:	Group Plan Name:

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4. SELECTED DENTAL COVERAGE

DENTAL PLANS

Initial One	DENTAL PLANS		
	Delta Dental PPO		
PREPAID DENTAL ENROLLEES ONLY: If you choose DeltaCare, indicate the number of the Dental Office you and your dependents will use.			
	DeltaCare USA (DMO) (CA only)	DENTAL OFFICE NUMBER	DENTIST'S NAME

PLAN OFFICE USE ONLY

Effective Date: ___________________________

ACT RET/SUR COBRA

Dental Plan: #__________________ *Delta* *USA*

5. SELECTED MEDICAL COVERAGE

MEDICAL PLANS

Initial One	COMPREHENSIVE MEDICAL/HOSPITAL PLANS	PREVIOUS MEMBER OF THIS PLAN			
		YES	NO	LAST DATE COVERED	PREVIOUS GROUP #
	ANTHEM BLUE CROSS PPO (Nationwide)				
	KAISER PERMANENTE HMO (CA ONLY)	◯	◯		
Plans listed below require that eligible members must receive all medical care through the Medical Group or Independent Practice Association (IPA) selected, and must live within the service area.					
	HEALTH NET HMO (CA ONLY)	◯	◯		
	OXFORD POS (NY, NJ & CT ONLY)	◯	◯		

PLAN OFFICE USE ONLY

Effective Date: _________________________

K *HNET* *OX* *ABC*

Medical Plan: #_________________________

NAME OF MEDICAL GROUP OR IPA SELECTED	FACILITY NUMBER

NAME OF MEDICAL GROUP OR IPA SELECTED	FACILITY NUMBER

6. IF YOU SELECTED KAISER YOU MUST READ AND SIGN KAISER'S ARBITRATION AGREEMENT

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulations, and any other claims that cannot be subject to mandatory binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

____ ____________________

Signature Required for Kaiser Permanente Plan **Date**

7. PARTICIPANT SIGNATURE

I understand this election will remain in effect until I make another election during an open enrollment period. I want to enroll myself and those eligible members of my family, listed above, for participation in the plan(s) it is my responsibility to immediately report any change of address and any change in the eligibility status of my dependents. I hereby authorize the Health Plan, any insurance company, organization, employer, hospita release any information required or requested to process any claim under the plan selected. ***I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.***

PARTICIPANT SIGNATURE: ____________________________________ ***DATE SIGNED*** ______________________

Rev. 3/17