MPI
MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

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Benefit Selection Form

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

Participant's Social Security Number	Last Name	First Name	M.I.	Birth Date	Gender (Circle One)
					☐ Male ☐ Female

Home Address	City	State	Zip	Marital Status (Circle One)	Day Phone
				☐ Single ☐ Married ☐ Divorced	

Home E-Mail	Alternative E-Mail	Mobile Phone	Home Fax

I have reviewed the dental plan options and elect coverage under the plan initialed below. I understand that benefits will only be available from the plan in which I have enrolled.

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*

I have reviewed the medical plan options and elect coverage under the plan initialed below. I understand that benefits will only be available from the plan in which I have enrolled.

MEDICAL PLANS

Initial One	COMPREHENSIVE MEDICAL/HOSPITAL PLANS	PREVIOUS MEMBER OF THIS PLAN YES	NO	LAST DATE COVERED	PREVIOUS GROUP #	NAME OF MEDICAL GROUP OR IPA SELECTED	FACILITY NUMBER
	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: #_____

LIST ALL ELIGIBLE DEPENDENTS TO BE ENROLLED IN THE PLANS SELECTED ABOVE

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 M/D/Yr	Gender (Circle One)	Social Security Number (Required)	See Codes Below	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				

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.

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

If yes, please provide: _____

Name of all family members enrolled, name of *group* health plan, policy number and effective date of other *group* insurance

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) elected. I also understand that 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, hospital, physician, or surgeon to 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*** _____