P.O. Box 1999, Studio City, CA 91614-0999
(855) ASK-4MPI

Motion Picture Industry Health Plan Beneficiary/Enrollment Form

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

This form is used to enroll you and your dependents in the Health Plan and to designate the beneficiary(ies) of your life insurance. Benefits will not commence and claims will not be paid until your Beneficiary/Enrollment form is received in the Plan office. Please note that _it must be completed 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	⑤ Female ⑤ Male

Mailing Address	City	State	ZIP Code	Daytime Phone Number ( )

Marital Status (Check One): ⑤ Widowed ⑤ Married ⑤ Divorced ⑤ Single	Date of Marriage	Date of Divorce	Spouse Date of Death	**SOCIAL SECURITY NUMBERS FOR ALL DEPENDENTS MUST BE PROVIDED**

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	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**

Your Biological Children Under 19 Years of Age

Last Name	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**
Last Name	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**
Last Name	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**
Last Name	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**
Last Name	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**

Your Non-Biological Children Under 19 Years of Age

Last Name	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**
Last Name	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**

Your Children Between 19 and 26 Years of Age

Last Name	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**
Last Name	First Name & M.I.	⑤ Female ⑤ Male	Date of Birth	**Social Security Number**

Life Insurance

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 designee is also listed below, s/he will not be considered your beneficiary. Your beneficiary must claim the life insurance within two years of your date of death. If your beneficiary does not make a claim within this two-year period, the benefit shall be irrevocably forfeited and donated 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 ⑤ Yes ⑤ 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 ⑤ Yes ⑤ 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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THIS FORM MUST BE COMPLETED AND RETURNED TO THE WEST COAST PLAN OFFICE

(Faxes will not be accepted.)

Remember To Update Your Pension Plan Beneficiary Form If You Have MPI Pension Plan Benefits.