

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

**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<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |
| <b>Your Biological Children Under 19 Years of Age</b>     |                   |  |               |                               |
| Last Name   | First Name & M.I. | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |
| Last Name   | First Name & M.I. | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |
| Last Name   | First Name & M.I. | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |
| Last Name   | First Name & M.I. | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |
| Last Name   | First Name & M.I. | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |
| <b>Your Non-Biological Children Under 19 Years of Age</b> |                   |  |               |                               |
| Last Name   | First Name & M.I. | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |
| Last Name   | First Name & M.I. | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |
| <b>Your Children Between 19 and 23 Years of Age</b>       |                   |  |               |                               |
| Last Name   | First Name & M.I. | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |
| Last Name   | First Name & M.I. | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth | <b>Social Security Number</b> |

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.

|   |            |             |              |   |
|---|------------|-------------|--------------|---|
| <b>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.</b>   |            |             |              |   |
| Last Name   | First Name | Middle Name | Relationship | Age   |
| Mailing Address   |            |             |              | Joint<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>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 &amp; Television Fund or any other charitable organization. If additional space is needed, you may attach a separate piece of paper.</b> |            |             |              |   |
| Last Name   | First Name | Middle Name | Relationship | Age   |
| Mailing Address   |            |             |              | Joint<br><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.

|  |      |                |
|--|------|----------------|
| <b>Signature of Participant Required</b> | Date | Union or Guild |
|--|------|----------------|