MOTION PICTURE INDUSTRY PENSION & HEALTH PLANS™

REQUEST FOR REFUND

Return this Form to: MPI Premium Department • P.O. Box 1999 • Studio City, CA 91614-0999

Use this form to request a refund of your health care premium balance. Complete and return the signed form to the address indicated above.

Please allow thirty (30) days for the processing of your request.

PARTICIPANT'S INFORMATION

Name: _____ **MPI ID:** _____

Address: _____

Email: _____ **Telephone:** _____

REFUND INFORMATION

Refund Amount: $ _____

Address: _____

Reason for Refund: _____

_____

_____

_____

Participant's Signature **Date**

PLEASE ALLOW THIRTY (30) DAYS FOR PROCESSING

For Office Use Only

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Eligibility Approval