



Requirements for Maintaining Health Insurance Coverage as a Full-Time Student

If your unmarried child is dependent upon you for primary support and is a full-time student in a fully accredited school or college, your child may remain eligible for MPI Health Plan benefits until his/her 23rd birthday or graduation, whichever comes first, provided the enclosed Student Certification Form is received by the MPI Health Plan. It is your responsibility to submit the Student Certification Form to MPI by fax: (818) 766-1229 or First Class mail: MPIHP, P.O. Box 1999, Studio City, CA, 91604-0990.

If your student falls below full-time status, he/she will become ineligible for benefits at the end of the month in which he/she withdraws from one or more classes (prior to the end of the session) bringing the total number of units or hours to below full-time. You must notify the MPI Health Plan immediately of the date of withdrawal.

Full-time status means:

- Quarterly System: Your child must attend at least three quarters per year and carry a minimum of 10 units per quarter.
- Semester System: Your child must attend two semesters per year (spring and fall) and carry a minimum of 12 units per semester.
- Trade, Technical or Adult Education: Your child must be in attendance 25 hours or more per week. Students attending school to acquire a high-school diploma are required to attend 20 hours per week.

For more information, please refer to your 2007 Summary Plan Description, which is available at www.mpiphp.org. Click on "Active Plan" link under the section titled "Your Benefits."

If you have any questions, please email MPI's Participant Services Center at service@mpiphp.org. If you prefer, you may send a fax to (818) 766-1229 or call toll-free (855) ASK-4MPI (855-275-4674), from 8 a.m. to 5 p.m. PST, Monday through Friday.

PARTICIPANT MUST COMPLETE AND AGREE TO THE FOLLOWING

Participant Name: _____ SSN or ID Number: _____

Address: _____

City ST Zip: _____

Dependent Name: _____

Dependent SSN: _____ Dependent Birth Date: _____

I hereby certify that my unmarried child named above is:

1. Dependent upon me for primary support, and
2. A full-time student in an accredited college or trade school.

School Name: _____

School Address: _____

Number of Credits/Units/Hours: _____ Enrollment period from: _____ to: _____
(mm/dd/yy) (mm/dd/yy)

- I understand that the Motion Picture Industry (MPI) Active Health Plan will rely on the information contained in this Certification to make its determination regarding my child's eligibility to receive benefits.
- I understand that I must notify the MPI Active Health Plan immediately if my child graduates or is no longer a full-time student. I understand that I am responsible for any expenses paid by MPI on behalf of my child for services incurred after he/she is no longer a full-time student.
- If my child is no longer a full-time student, I understand that he/she may be eligible to continue hospital, medical and prescription benefits (not vision or dental benefits) through the MPI Active Health Plan up to age 26, but I must re-enroll my child separately for access to these benefits.
- I understand that the MPI Active Health Plan reserves the right to periodically conduct an audit to verify that my child was a qualified full-time student during the period in which health coverage was provided, and I agree to cooperate fully in any such audit.
- If the audit shows that my child was not a full-time student during the period in which health coverage was provided, I will assume responsibility for any expenses paid out by MPI for the ineligible period(s). If I do not refund the amount that is requested, MPI may withhold any payment of future claims otherwise due to me and my qualified dependents, including payment for medical visits, prescription and hospital costs, dental and vision care, and offset that against the amount that I owe.

I hereby certify that the above statements are true and correct, and I acknowledge that it is fraudulent to knowingly falsify information on this form.

Participant's Signature: _____ Date: _____