



**Medical/Hospital/Dental Plan
Selection Form**

Instructions

P.O. Box 1999, Studio City, CA 91614-0999
818 or 310.769.0007, Ext. 263 – www.mpiphp.org

Attached you will find your medical/hospital and dental plan selection form.

You only need to complete this form if:

- You are initially or newly eligible.
- You wish to change the medical/hospital and/or the dental plan in which you are currently enrolled.
- You are electing COBRA self-pay as an individual and are enrolled in one of our HMO plans (Kaiser, Health Net, Oxford, or DeltaCare USA)

If none of the above circumstances apply to you,
please disregard this selection form.

To properly fill out your selection form, you will need to do the following:

1. Complete all requested participant information.
2. Select one dental and one medical/hospital plan. If you are initially or newly eligible and no selection is made, you will automatically be enrolled in the MPIHP/Blue Shield of California Indemnity Plan and the Delta Dental PPO Plan. Please refer to the Summary Plan Description on the different plans available. Review this information very carefully as each plan is different. ***New participants must return the beneficiary/enrollment card before the benefits of any plan are available.***
3. List all eligible dependents to be enrolled in your selected plans. ***Copies of marriage and/or birth certificates are required to enroll all dependents.*** For additional information on eligible dependents, please refer to your Summary Plan Description.
4. Provide information on other Group insurance for you or any family members where indicated. ***Failure to provide this information may result in the delay and/or denial of payment of your dependent's claims.***
5. Sign and date the enrollment form.

If you wish to change your medical/hospital or dental plan, this form must be completed in full and returned to the Plan office. HMO and pre-paid dental plan coverage will be effective on the 1st of the month following the receipt of your selection form. Failure to complete this form in full or provide the necessary documentation will result in a delay of processing your enrollment.

MOTION PICTURE INDUSTRY HEALTH PLAN

Eligibility Department



11365 Ventura Boulevard • Studio City, California 91604-3148
 Mailing Address:
 P.O. Box 1999 • Studio City, California 91614-0999
 818 or 310.769.0007 x263 • Outside So. Cal. 888.369.2007
 FAX: 818.766.1229 • www.mpiphp.org

Benefit Selection Form

The **new** contact information you provide will be used to update the records maintained at both the Motion Picture Industry Health Plan and the Motion Picture Industry Pension Plan, as applicable.

Social Security Number	Last Name	First Name	M.I.	Birth Date	Gender (Check One) Male Female
Home Address	New Address? Yes No	City	State	ZIP	Marital Status (Check One) Single Married/Domestic Divorced
Home E-mail	Home FAX	Pager	Mobile Phone	Work Phone	Work FAX
Home Phone					

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	PLAN OFFICE USE ONLY		
		DELTA DENTAL PPO	EligID _____		
	PREPAID DENTAL ENROLLEES ONLY: If you choose DeltaCare, indicate the number of the Dental Office you and your dependents will use.		Effective Date: _____		
	DeltaCare USA (CA services area only)	Dental Office Number	Dentist's Name	ACT	RET/SUR
Dental Plan: # _____ DD/PPO DC/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 PLAN				PLAN OFFICE USE ONLY		
		MPIHP / BLUE SHIELD OF CALIFORNIA (Nationwide)				Effective Date: _____		
		HEALTH MAINTENANCE ORGANIZATION	Previous Member of This Plan				K	HNET
		KAISER PERMANENTE (California Only)	YES	NO	LAST DATE COVERED	PREVIOUS GROUP #	OX	BS/PPO
	Medical Plan: # _____							
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 (California Only)					Name of Medical Group or IPA Selected	Facility Number	
	OXFORD (NY, NJ, CT Area Only)					Name of Medical Group or IPA Selected	Facility Number	

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.

Employee & 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 (Check One)		Social Security Number (Required)	See Codes Below	Name of Primary Care Physician <i>Only</i> if you selected an IPA above
Last Name (Spouse/Domestic Partner)			M	F			Physician / Facility Number
Last Name (Child)			M	F			
Last Name (Child)			M	F			
Last Name (Child)			M	F			
Last Name (Child)			M	F			

Status Codes: SP - Spouse DP - Domestic Partner CH - Biological Child FC - Foster Child AD - Adopted Child LG - Legal Guardianship SC - Step Child ST - Student (Age 19 - 23) HN - Disabled (Over Age 18)
 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: _____ If yes, please provide: _____
 Name(s) of the Insured(s) Name, Policy Number and Effective date of other Group Medical 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 family members of my family, listed above, for participation in the plan elected. I also understand that it is my responsibility to 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.**

EMPLOYEE SIGNATURE _____ DATE SIGNED _____