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# 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 Phone
Home E-mail		Home FAX		Pager		Mobile Phone		Work Phone		Work FAX Work E-mail	

**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.**

<b>Dental Plans</b>	<b>Initial One</b>	DENTAL PLANS		<b>PLAN OFFICE USE ONLY</b>		EligID _____
		DELTA DENTAL PPO		Effective Date: _____		
	<b>PREPAID DENTAL ENROLLEES ONLY: If you choose DeltaCare, indicate the number of the Dental Office you and your dependents will use.</b>					
		DeltaCare USA (CA services area only)		Dental Office Number	Dentist's Name	
						ACT RET/SUR COBRA
						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.**

<b>Medical Plans</b>	<b>Initial One</b>	COMPREHENSIVE MEDICAL / HOSPITAL PLAN				<b>PLAN OFFICE USE ONLY</b>	
		MPIHP / BLUE SHIELD OF CALIFORNIA (Nationwide)				Effective Date: _____	
		HEALTH MAINTENANCE ORGANIZATION		Previous Member of This Plan		K HNET OX BS/PPO	
		YES	NO	LAST DATE COVERED	PREVIOUS GROUP #	Medical Plan: # _____	
		KAISER PERMANENTE (California Only)					
<b>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.</b>							
	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)		See Codes Below	Name of Primary Care Physician <i>Only</i> if you selected an IPA above	
			M	F		Physician / Facility Number	
Last Name (Spouse/Domestic Partner)			M	F			
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: \_\_\_\_\_ Name(s) of the Insured(s)  
 If yes, please provide: \_\_\_\_\_ 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 \_\_\_\_\_