ACTIVE + RETIREE HEALTH PLANS

Enrollment + Beneficiary Designation Form

MOTION PICTURE INDUSTRY PENSION & HEALTH PLANS™

Instructions

- This form is used to enroll you and your dependents in the Active and Retiree Health Plans through the Motion Picture Industry Pension & Health Plans (MPIPHP) and to designate the beneficiary(ies) of your life insurance.
- Information submitted by you to the Plan Office will be used to update records at the Motion Picture Industry Pension, Individual Account and Health Plans.
- Benefits will **not** commence and claims will not be paid until your Enrollment + Beneficiary Designation Form is received in the Plan Office. Please note that **it must be completed and signed by the Participant** before it will be accepted as a valid record.
- Remember to update your Pension Plan Beneficiary Form if you have Motion Picture Industry Pension Plan benefits
- If additional space is needed, you may attach an additional form.

COMPLETE THIS FORM & RETURN TO:

Motion Picture Industry
Pension & Health Plans
P.O. Box 1999, Studio City, CA 91614-0999

- Faxes, emailed or copied versions of this form will **not** be accepted.
- **Questions?** Email service@mpiphp.org or call MPIPHP toll-free at (855) 275-4674 from 6 a.m. to 7 p.m. PST, Monday through Friday.

Participant

LAST NAME	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER / MPI ID
MAILING ADDRESS		CITY	STATE	ZIP CODE	MOBILE PHONE NUMBER ( )
MARITAL STATUS (CHECK ONE): ☐ **Widowed** ☐ **Married** ☐ **Divorced** ☐ **Single**		DATE OF MARRIAGE	DATE OF DIVORCE		SPOUSE DATE OF DEATH

Health Plan: Dependents

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. Social Security numbers for all dependents **must** be provided.

LAST NAME OF SPOUSE	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
YOUR BIOLOGICAL CHILDREN UNDER 26 YEARS OF AGE					
LAST NAME	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
LAST NAME	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
LAST NAME	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
LAST NAME	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
YOUR NON-BIOLOGICAL CHILDREN UNDER 26 YEARS OF AGE					
LAST NAME	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
LAST NAME	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
LAST NAME	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
LAST NAME	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Life Insurance: Beneficiaries

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 designee is also listed below, s/he will not be considered your beneficiary. Your beneficiary **must claim the life insurance within two years** of your date of death. If your beneficiary does not make a claim within this two-year period, the benefit shall be irrevocably forfeited and donated to the Motion Picture & Television Fund.

Designate your Beneficiary and any Contingent Beneficiaries in the spaces below, in order of preference. **If the benefit is to be shared ("Joint"), please specify.** If you check "Yes," the benefit will be divided equally. If you check "No," the first listed beneficiary will be the only one paid. If there is no other person you wish to designate, you may list the Motion Picture & Television Fund or any other charitable organization. If additional space is needed, you may attach a separate piece of paper.

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP		AGE
MAILING ADDRESS		CITY	STATE	ZIP CODE	JOINT BENEFICIARY? ☐ YES ☐ NO
CONTINGENT BENEFICIARY(IES)					
LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP		AGE
MAILING ADDRESS		CITY	STATE	ZIP CODE	JOINT BENEFICIARY? ☐ YES ☐ 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. I acknowledge that it is fraudulent to knowingly fill out this form with any information that is false.

SIGNATURE OF PARTICIPANT REQUIRED	DATE	UNION OR GUILD