# ACTIVE + RETIREE HEALTH PLANS Spouse: Coordination of Benefits — Form (1)

#### Instructions

- The Coordination of Benefits Forms apply to Participants and their dependents when enrolling in the Motion Picture Industry Health Plan's (MPIHP) Preferred Provider Option Plan and Oxford Health Plans Point of Service Plan.
- This form is used to allow the MPIHP to properly coordinate benefits for your spouse and dependents.
- If your spouse is eligible for medical, hospital and/or prescription benefits through his/her own employer, your spouse **must** enroll for that insurance as his/her primary coverage as soon as it is available, regardless of cost. MPIHP then will be the **secondary coverage** for those benefits and will remain the primary coverage for dental and vision benefits.
- If your spouse misses the open enrollment date and is not able to enroll until the next open enrollment period, MPIHP will **cancel** all of his/ her benefits including dental and vision until your Spouse is enrolled in his/her employer's group insurance.
- If any information on this form changes, a new form must be submitted within 30 days.
- 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.

- If Spouse is unemployed, self-employed, a freelancer or retired without group insurance, you will need to complete the "Spouse: Coordination of Benefits"-Forms 1 & 3.
- If Spouse is employed (full-time or part-time) or retired with group insurance, you will need to have the Spouse's Employer complete the top portion of the "Spouse: Coordination of Benefits" - Forms 1 & 2.
- Incomplete forms and/or forms missing Participant's, spouse's or employer's signatures will be returned. Failure to provide this information may result in the delay and/or denial of payment of your dependent's claims.

#### Eligibility and Coordination of Benefits for Dependent Children:

If a spouse enrolls his or her dependent child(ren) in his or her Employer's health plan, that plan may be considered primary for the child(ren). The determination of which coverage is primary will be made based on whose birthday comes first in the year. If the spouse's birthday is earlier than the Participant's, his or her insurance will be considered primary. If the Participant's birthday comes first, MPIHP will be primary for the dependent child(ren).

If a spouse enrolls in his or her Employer's health coverage and dependent child(ren) can be enrolled at no additional charge, such dependents must be enrolled. If they are not enrolled under these circumstances, MPIHP will provide no coverage to such dependent child(ren).

## COMPLETE THIS FORM & RETURN TO: Motion Picture Industry

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

- ► Form may be emailed to service@mpiphp.org or faxed to (818) 766-1229.
- 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.



Form: 150\_V01

# **ACTIVE + RETIREE HEALTH PLANS**

Spouse: Coordination of Benefits – Form (1)



Participant Pension & Health Plans									
LAST NAME	FIRST NAME	MIDDLE NAME	FEMALE MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER / MPI ID				
MAILING ADDRESS		CITY	STATE	ZIP CODE	PHONE NUMBER				
DO YOU HAVE A HEALTH INSURANCE PLAN OTHER THAN THE MPIHP?									
□ YES → □ Group Policy: Sin	gle 🛛 Group Policy: Family	🗆 Individual 🗆 Medicare 🗆	Retired		→ Move on to Section 2				

□ Part "B" - Effective:

PLEASE LIST NAMES OF ALL FAMILY MEMBERS ENROLLED:							
LAST NAME	FIRST NAME	MIDDLE NAME	□ FEMALE □ MALE	DATE OF BIRTH	EFFECTIVE DATE		
LAST NAME	FIRST NAME	MIDDLE NAME	□ FEMALE □ MALE	DATE OF BIRTH	EFFECTIVE DATE		
LAST NAME	FIRST NAME	MIDDLE NAME	□ FEMALE □ MALE	DATE OF BIRTH	EFFECTIVE DATE		
LAST NAME	FIRST NAME	MIDDLE NAME	□ FEMALE □ MALE	DATE OF BIRTH	EFFECTIVE DATE		
LAST NAME	FIRST NAME	MIDDLE NAME	□ FEMALE □ MALE	DATE OF BIRTH	EFFECTIVE DATE		
GROUP OR INDIVIDUAL HEALTH PLAN NAME			POLICY NUMBER		EFFECTIVE DATE		
MAILING ADDRESS		СІТҮ	STATE	ZIP CODE	PHONE NUMBER		

Spouse

FIRST NAME	MIDDLE NAME	□ FEMALE □ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER				
□ SPOUSE IS EMPLOYED → □ Full-Time □ Part-Time □ Self-Employed □ Freelance □ NOT EMPLOYED →								
Are group health benefits available? □ YES □ NO → 500 → Move on to Section 3								
What type of coverage is available? 🛛 Medical/Hospital 🖓 HMO 🖓 Rx 🖓 Other:								
<b>?</b> □ <b>YES</b> → Effective:	🗆 Medicare Part "A" - E	ffective:	🗆 Part '	□ Part "B" - Effective:				
	] Full-Time □ Part-Time □ So ailable? □ YES □ NO → ᡂ ilable? □ Medical/Hospital	Image: Full-Time       □ Part-Time       □ Self-Employed       □ Freelance         ailable?       □ YES       □ NO → (10)       → Move on to Section 3         ilable?       □ Medical/Hospital       □ HMO       □ Rx       □ Other:	□ Full-Time       □ Part-Time       □ Self-Employed       □ Freelance       □ NOT E         ailable?       □ YES       □ NO → (10) → Move on to Section 3       □         ilable?       □ Medical/Hospital       □ HMO       □ Rx       □ Other:	□ Full-Time       □ Part-Time       □ Self-Employed       □ Freelance       □ NOT EMPLOYED → @         ailable?       □ YES       □ NO → @ → Move on to Section 3       →         ilable?       □ Medical/Hospital       □ HMO       □ Rx       □ Other:				

### **Confirmation / Signature**

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT, and I understand that, to ensure that benefits are coordinated properly, the MPIHP will verify the accuracy of information by conducting audits, contacting me, my spouse's employer, and/or insurance plan. It is fraudulent to knowingly fill out this form with any information that is false.

SIGNATURE OF PARTICIPANT REQUIRED

DATE