

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 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.
- ▶ 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.

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 online at www.mpiphp.org

- ▶ **Questions?** Send us a secure email by using the Contact Us button on www.mpiphp.org or call MPIPHP toll-free at (855) 275-4674 from 6 a.m. to 6 p.m. PST, Monday through Friday.

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Spouse: Coordination of Benefits — Form 1



1 Participant Information

PREFIX	LAST NAME	SUFFIX	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	SOCIAL SECURITY OR MPI ID NUMBER
ADDRESS LINE 1			EMAIL	MOBILE PHONE NUMBER ()		HOME / ALTERNATE PHONE NUMBER ()	
ADDRESS LINE 2			CITY	STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY	

DO YOU HAVE A HEALTH INSURANCE PLAN OTHER THAN THE MPIHP?

YES → Group Policy: Single Group Policy: Family Individual Medicare Retired

NO → → Move on to Section 2

If it is a Medicare policy, please indicate the following: Part "A" - Effective:

Part "B" - Effective:

GROUP OR INDIVIDUAL HEALTH PLAN NAME	POLICY NUMBER	GROUP NUMBER (IF APPLICABLE)	PHONE NUMBER ()	EFFECTIVE DATE
MAILING ADDRESS		CITY	STATE/PROVINCE	ZIP/POSTAL CODE

PLEASE LIST NAMES OF ALL FAMILY MEMBERS ENROLLED:

PREFIX	LAST NAME	SUFFIX	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	EFFECTIVE DATE
PREFIX	LAST NAME	SUFFIX	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	EFFECTIVE DATE
PREFIX	LAST NAME	SUFFIX	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	EFFECTIVE DATE
PREFIX	LAST NAME	SUFFIX	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	EFFECTIVE DATE
PREFIX	LAST NAME	SUFFIX	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	EFFECTIVE DATE

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2 Spouse Information

PREFIX	LAST NAME	SUFFIX	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	SOCIAL SECURITY NUMBER
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SPOUSE IS EMPLOYED → Full-Time Part-Time Self-Employed Freelance

NOT EMPLOYED → **STOP** → Move on to **Section 3**

Are group health benefits available? **YES** **NO** → **STOP** → Move on to **Section 3**

What type of coverage is available? Medical/Hospital HMO Rx Other:

Are you entitled to Medicare? **YES** → Effective:

Medicare Part "A" - Effective:

Part "B" - Effective:

3 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.

PARTICIPANT'S SIGNATURE

DATE