

### Instructions

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- ▶ 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.
- ▶ Incomplete forms and/or forms missing Participant's, spouse's or employer's signatures **will be returned**.
- ▶ 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 any information on this form changes, a new form must be submitted within 30 days.

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

If your Spouse's birth date is earlier in the year than yours, your eligible dependent children must be enrolled in the insurance available to your spouse through his/her employer, unless your spouse's group health plan charges a premium to cover your dependent children.

It is the Participant's responsibility to notify MPIHP of any change to their spouse's insurance or employment status immediately and no later than 30 days of such change. Failure to do so can result in the termination of coverage and denial of claims.

### Complete this form online at [www.mpiphp.org](http://www.mpiphp.org)

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

# ACTIVE + RETIREE HEALTH PLANS

## Spouse: Coordination of Benefits — Form ②



### 1 Employer Information: (To be completed by your Spouse's employer)

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE NAME	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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EMPLOYER NAME

MAILING ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( )
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#### DO YOU OFFER EMPLOYER GROUP HEALTH INSURANCE TO THIS EMPLOYEE?

**YES** → Select one:  **Active Policy**  **Retiree Policy**       **NO** → Please sign below and return original form to Employee

#### IS THE EMPLOYEE ENROLLED IN THE COMPANY'S GROUP HEALTH INSURANCE?

**YES** → Enrollment date: \_\_\_\_\_       **NO** → Next Open Enrollment date: \_\_\_\_\_      Effective date: \_\_\_\_\_

Is a premium required for Group Insurance for children?  **YES**  **NO**

#### PLEASE LIST NAMES OF ALL FAMILY MEMBERS ENROLLED:

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

GROUP HEALTH PLAN NAME	POLICY NUMBER	GROUP NUMBER
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MAILING ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER ( )
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▶ 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.

AUTHORIZED EMPLOYER SIGNATURE	TITLE	TELEPHONE/EXT	DATE
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### 2 Participant + Spouse:

PARTICIPANT'S LAST NAME	FIRST NAME	MIDDLE NAME	MOBILE PHONE NUMBER ( )	SOCIAL SECURITY NUMBER
SPOUSE'S LAST NAME	FIRST NAME	MIDDLE NAME	MOBILE PHONE NUMBER ( )	SOCIAL SECURITY NUMBER

▶ I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT, and I understand that, to ensure that benefits are coordinated properly, the Motion Picture Industry Health Plan ("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. I agree that if any information on this form changes, I must notify the Plan Office immediately and submit an updated form within 30 days of such change. I understand failure to notify the MPIHP in writing within 30 days of a change in the health coverage for my spouse, or a change in his or her eligibility for coverage through my spouse's employer, is a misrepresentation that may result in retroactive termination of benefits for my spouse.

SIGNATURE OF PARTICIPANT REQUIRED	DATE	UNION OR GUILD
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SIGNATURE OF SPOUSE REQUIRED	DATE
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