ACTIVE + RETIREE HEALTH PLANS
Participant: Benefits Selection Form

OPEN ENROLLMENT 2023

MOTION PICTURE INDUSTRY PENSION & HEALTH PLANS™

Instructions

- This form is used to designate the benefits you and your dependents receive through the Motion Picture Industry Health Plan (MPIHP).
- 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.
- Copies of birth certificates, marriage certificates, and/or other forms of documentation (dependent applications, divorce/custody documents), along with the Enrollment & Beneficiary Designation Form are **required** to enroll dependents.
- This election will remain in effect until the Participant makes another election during an open enrollment period.
- It is the Participant's responsibility to **immediately report** any change of address and any change in the eligibility status of his/her dependents.

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 6 p.m. PST, Monday through Friday.

1 Participant Information

PREFIX	LAST NAME	SUFFIX	FIRST NAME	MIDDLE NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY OR MPI ID NUMBER

ADDRESS LINE 1 (HMO PLANS DO NOT ACCEPT P.O. BOXES)	EMAIL	MOBILE PHONE NUMBER	HOME / ALTERNATE PHONE NUMBER

ADDRESS LINE 2	CITY	STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY

MARITAL STATUS (CHECK ONE):	DATE OF MARRIAGE	DATE OF DIVORCE	SPOUSE'S DATE OF DEATH
☐ **Widowed** ☐ **Married** ☐ **Divorced** ☐ **Single**			

2 Health Plan: Participant + Dependents

List yourself and all your eligible dependents in the spaces provided below. Consult the *Summary Plan Description* for the documents required to determine eligibility for dependents. Social Security numbers for all dependents **must** be provided. If you choose **HEALTH NET** or **OXFORD**, you will need to use a **HEALTH NET** or **OXFORD** Provider Directory to choose a Primary Care Physician for you and your dependents.

DEPENDENT STATUS CODES: **SP** - Spouse **CH** - Biological Child **FC** - Foster Child **AD** - Adopted Child **LG** - Legal Guardianship **SA** - Step Child **ST** - Student (Age 19-23) **HN** - Disabled (Over Age 19) **C2** - Adult Dependent (Over Age 19)

LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	STATUS CODE	IPA PRIMARY CARE PHYSICIAN	IPA PHYSICIAN / FACILITY NUMBER
LAST NAME (SELF)	FIRST NAME					IPA PRIMARY CARE PHYSICIAN	IPA PHYSICIAN / FACILITY NUMBER
LAST NAME (SPOUSE)	FIRST NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	STATUS CODE **SP**	IPA PRIMARY CARE PHYSICIAN	IPA PHYSICIAN / FACILITY NUMBER
LAST NAME (CHILD)	FIRST NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	STATUS CODE	IPA PRIMARY CARE PHYSICIAN	IPA PHYSICIAN / FACILITY NUMBER
LAST NAME (CHILD)	FIRST NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	STATUS CODE	IPA PRIMARY CARE PHYSICIAN	IPA PHYSICIAN / FACILITY NUMBER
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LAST NAME (CHILD)	FIRST NAME	☐ FEMALE ☐ MALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	STATUS CODE	IPA PRIMARY CARE PHYSICIAN	IPA PHYSICIAN / FACILITY NUMBER

—SEE NEXT PAGE—

3 Other Group Insurance

DO YOU OR ANY FAMILY MEMBERS HAVE OTHER GROUP MEDICAL INSURANCE?

☐ **YES** ➞ Please print the information about your or your family member's other group insurance plan in the spaces below ☐ **NO** ➞ STOP ➞ Move on to **Section 4**

LAST NAME	FIRST NAME	INSURANCE COMPANY	POLICYHOLDER'S NAME	EFFECTIVE DATE	POLICY NUMBER	GROUP NUMBER	POLICY TYPE
							☐ SINGLE ☐ FAMILY ☐ RETIREE ☐ ACTIVE
							☐ SINGLE ☐ FAMILY ☐ RETIREE ☐ ACTIVE
							☐ SINGLE ☐ FAMILY ☐ RETIREE ☐ ACTIVE
							☐ SINGLE ☐ FAMILY ☐ RETIREE ☐ ACTIVE
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							☐ SINGLE ☐ FAMILY ☐ RETIREE ☐ ACTIVE

4 Dental Plans: Coverage Options

(PLEASE SELECT ONE OF THE FOLLOWING PROVIDERS AND INITIAL BESIDE YOUR CHOICE)

Plan	Type	Area	INITIAL
☐ **Delta Dental**	**PPO**	**Nationwide**	
☐ **DeltaCare USA**	**DMO**	**CA Only**	

! IF YOU CHOOSE DELTACARE USA, INDICATE THE OFFICE ID NUMBER OF THE DENTAL OFFICE YOU AND YOUR DEPENDENTS WILL USE."

DENTIST'S NAME	DENTAL OFFICE ID NUMBER

PLAN OFFICE USE ONLY: **Effective Date** ____________ ☐ **ACT** ☐ **RET/SUR** ☐ **COBRA** **Dental Plan #** ____________ ☐ **Delta** ☐ **USA**

—SEE NEXT PAGE—

5 Medical Plans: Coverage Options

(PLEASE SELECT ONE OF THE FOLLOWING PROVIDERS AND INITIAL BESIDE YOUR CHOICE)

☐ **Anthem Blue Cross**	**PPO**	**Nationwide**	INITIAL	
☐ **Kaiser Permanente**	**HMO**	**CA Only**	INITIAL	**Previous member of this plan?** ☐ **NO** ☐ **YES** ➞ Last Date Covered: Previous Group #
☐ **Health Net**	**HMO**	**CA Only**	INITIAL	**Previous member of this plan?** ☐ **NO** ☐ **YES** ➞ Last Date Covered: Previous Group #
☐ **Oxford**	**POS**	**NY, NJ & CT Only**	INITIAL	**Previous member of this plan?** ☐ **NO** ☐ **YES** ➞ Last Date Covered: Previous Group #

HEALTH NET AND OXFORD 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.

NAME OF SELECTED MEDICAL GROUP OR IPA	FACILITY NUMBER

PLAN OFFICE USE ONLY: **Effective Date** _____ ☐ **K** ☐ **HNET** ☐ **OX** ☐ **ABC** **Medical Plan #** _____

6 Kaiser Permanente Medical Plan

► **IF YOU SELECTED KAISER PERMANENTE AS YOUR MEDICAL PLAN, YOU MUST READ AND SIGN KAISER PERMANENTE'S ARBITRATION AGREEMENT:**

► I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulations, and any other claims that cannot be subject to mandatory binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

PARTICIPANT'S SIGNATURE DATE

7 Confirmation / Signature

► 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. 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 members of my family, listed above, for participation in the plan(s) elected. I also understand that it is my responsibility to immediately 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.

PARTICIPANT'S SIGNATURE DATE