

**COMPLETION INSTRUCTIONS**

The AFTRA Health Plan allows participants to enroll qualified dependents at the start of a four-quarter Coverage Period<sup>1</sup>; or after a Coverage Period begins under the conditions described below.

A completed Dependent Change Form (see reverse) and the required documentation (see the chart below) must be received by the Eligibility Department in the AFTRA H&R New York office within the time frames outlined below:

- At least 45 days prior to the start of the Coverage Period in which a participant wishes to add a dependent; or,
- Within 30 days after the date a participant acquires a new dependent, the dependent loses other health insurance or group health plan coverage including COBRA, or a COBRA premium subsidy provided by a former employer ends. Dependents added during a participant’s Coverage Period will be enrolled retroactive to the date of the event that resulted in their qualification.

*Note: If you divorce from your spouse, he/she is no longer a qualified dependent. AFTRA H&R requires that, within 60 days after the judgment of Dissolution of Marriage is recorded, you must notify us in writing and submit a true copy of the recorded final divorce decree. For same-sex domestic partnership changes, please call Participant Services at (800) 562-4690 for instructions.*

Please sign and fax your completed Dependent Change Form, as well as any required documentation, to (212) 499-4934 or mail it to:

**AFTRA Health & Retirement Funds**  
Attention: Eligibility Department  
261 Madison Avenue, 7th Floor  
New York, NY 10016

When the Eligibility Department receives and accepts your dependent change request, an invoice will be mailed to your last known address if any additional AFTRA Health Plan premium is due. The premium must be paid in full by the date specified on the invoice before the dependent can be enrolled. Before submitting a dependent change request, you should call Participant Services at (800) 562-4690 to confirm your enrollment information on file with AFTRA H&R, including your current mailing address.

The Dependent Change Form documentation requirements by type of dependent are summarized in the following chart:

Type of Dependent	Documentation Requirement
Legal Spouse	Copy of legally recorded marriage certificate
Divorced Spouse	Copy of the recorded judgment of “Dissolution of Marriage”
Same-Sex Domestic Partner	Fully executed and notarized Domestic Partner Enrollment Form package – Call Participant Services for more information or download the forms at <a href="http://www.aftrahr.com">www.aftrahr.com</a> (“Forms”   “Health forms”)
Biological children under age 26	Copy of the recorded birth certificate <sup>2</sup>
Adopted children under age 26	Copy of the adoption papers issued by the court or a letter of placement by an adoption agency
Children age 26 and over who remain dependent due to a physical or mental disability	Letter from the child’s treating physician certifying the nature of the impairment, the date of onset and the prognosis. Additional information may be requested in a form satisfactory to AFTRA H&R.

The AFTRA Health Plan includes a coordination of benefits provision (COB) for enrolled participants and their dependents covered under another health insurance policy or group health plan. You have an obligation to inform AFTRA H&R about the existence of any other health insurance policy or group health plan covering you or any of your dependents in addition to the AFTRA Health Plan. To receive the health benefits to which you and your dependent(s) are entitled, you or your health care provider must file a claim with each insurer or group plan that covers you and/or your dependent(s).

<sup>1</sup>The Coverage Period is the four calendar quarters during which a performer is qualified for health coverage under the Plan. Qualified performers may or may not choose to enroll in coverage.

<sup>2</sup>AFTRA H&R will accept a copy of an official birth record (e.g. a hospital release form that lists the mother’s and child’s names) to add your biological child to coverage for a period of 90 days from the date of birth while you obtain a recorded birth certificate.

**AFTRA HEALTH PLAN  
DEPENDENT CHANGE FORM**

Please read the instructions on page 1 before completing the Dependent Change Form.

**SECTION I: PARTICIPANT INFORMATION**

Social Security No. \_\_\_\_\_ H&R Funds No. \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

**SECTION II: DEPENDENT CHANGE REQUEST**

List the dependents you wish to enroll in the AFTRA Health Plan or drop from your coverage.

Last Name/First Name/MI	Gender (M/F)	Date of Birth MM/DD/YYYY	Social Security No.	Relationship*	Change Request
					Add Drop
					Add Drop
					Add Drop

\*Relationship means marital/partnership, parental or guardianship status, i.e., legal spouse (opposite or same-sex), same-sex domestic partner, biological child, stepchild, adopted child or foster child.

If you are adding a dependent(s) because of their loss of other health insurance or group health plan coverage including COBRA, or because a COBRA premium subsidy provided by their former employer has ended, please state the details below **and submit a copy of the Certificate of Creditable Coverage**. (If you require additional space, please attach a separate piece of paper.)

Describe change in employment status: \_\_\_\_\_

Date of the change in employment status that resulted in the loss of coverage (MM/DD/YYYY): \_\_\_\_\_

Date other health insurance or group health plan coverage terminated (MM/DD/YYYY): \_\_\_\_\_

Please certify that the above adult children are not eligible to enroll in other employer-sponsored group health coverage (other than coverage by a parent) by checking the following box:

I do so certify.

**SECTION III: ALTERNATE HEALTH COVERAGE INFORMATION**

Are any of the dependents added above enrolled in another health insurance policy or group health plan?  Yes  No

If you answered "Yes," please complete the following section for you and each dependent covered by another health insurance policy or group health plan. (If you require additional space, please attach a separate piece of paper.)

Name of Covered Individual \_\_\_\_\_ Policy/Plan No. \_\_\_\_\_

Insurer/Plan Name \_\_\_\_\_ Policy/Plan Effective Date (MM/DD/YYYY) \_\_\_\_\_

Address of Insurer/Plan \_\_\_\_\_

**SECTION IV: DECLARATION AND AUTHORIZATION**

I certify that all the information provided on this form and in any attached documents is accurate and complete, and I understand that providing false information to the AFTRA Health Plan may result in the denial, suspension or discontinuance of benefits for me and my dependents. I also acknowledge that the AFTRA Health Plan reserves the right to recover any health claim overpayments that result from false information provided on this form or its attachments.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian Signature (if applicable\*) \_\_\_\_\_ Date \_\_\_\_\_

\*This is a confidential legal document and must only be signed by the Participant. If the Participant is a minor, this document must be signed by the parent or legal guardian.