

## COMPLETION INSTRUCTIONS

*Dear Qualified Performer: Congratulations on having qualified for the valuable benefits offered through the AFTRA Health Plan. Please read and follow these instructions carefully in order to complete the Enrollment Form. The information you provide is needed by AFTRA H&R to properly administer your benefits under the AFTRA Health Plan. This form is a confidential legal document. AFTRA H&R is committed to maintaining and protecting the privacy of the personal information you provide as required by federal law. To begin the enrollment process you must complete, sign and date the form, then mail the original and copies of any required documents to:*

**AFTRA Health & Retirement Funds  
Attention: Eligibility Department  
261 Madison Avenue, 8th Floor  
New York, New York 10016**

*As a qualified performer enrolling in the AFTRA Health Plan, you are obligated to provide AFTRA H&R with up-to-date information regarding you and, if applicable, your dependent(s) and/or representative (e.g., business manager or agent). Providing all the requested information and keeping it current is the best way to ensure that you and your dependent(s) receive the benefits to which you are entitled. We recommend that you review your enrollment information on file with AFTRA H&R each year for completeness and accuracy. Generally, you have 30 days to notify AFTRA H&R in writing about life events that may affect your coverage with the AFTRA Health Plan (e.g., marriage, birth, adoption, divorce, relocation, employment changes, other health coverage changes, disabilities, death.) For information about AFTRA H&R's written notice and documentation requirements for adding or removing dependents, see below and visit our Web site at [www.aftrahr.com](http://www.aftrahr.com), or call Participant Services at 1-800-562-4690.*

**When completing this form, print legibly on a hard copy or enter information directly into the .PDF before printing.  
All sections must be completed fully and accurately, and all required documents must be provided,  
for your Enrollment Form to be processed by AFTRA H&R.**

## SECTION I: PERFORMER INFORMATION

**Performer Information:** The following information must be provided about the performer: Social Security No., Gender, Date of Birth, Alternate Tax ID No. and Alternate Tax Name (if applicable)\*, Legal Name and Mailing Address.

*\*If employer contributions for your AFTRA-Covered Earnings are reported under an Alternate Tax ID No. or FSO (for services of) agreement, please enter the Alternate Tax ID No. (i.e., the Employer Identification No.) and Alternate Tax ID Name of the company associated with these earnings in the spaces provided. If you have done covered work under multiple Tax IDs, please list them along with the Alternate Tax Names on a separate piece of paper. Providing this information will help us ensure that future earnings reported under these Alternate Tax IDs and Names are properly credited to you.*

If you provided both a Legal Name and a Professional Name, please place a check mark next to the name you want AFTRA H&R to use for correspondence and other business purposes. If neither box is checked, we will use your Legal Name.

**Mailing Address and Other Contact Information:** If you are providing information about your Representative's Office, you also must complete a Privacy Authorization Form. The form is available at [www.aftrahr.com](http://www.aftrahr.com) under the Forms/Health forms/Privacy forms tabs, or call Participant Services at 1-800-562-4690 to request a form.

**Marital Status:** Check the box that applies to your status. If you are legally married (opposite or same-sex) or in a same-sex domestic partnership, please indicate the date the marriage or partnership was legally recorded.

## SECTION II: DEPENDENT INFORMATION

**Dependent Information:** This section must be completed fully and accurately for all dependents you wish to enroll.

**Dependent Legal Spouse or Same-Sex Domestic Partner:** The following information must be provided about your spouse or domestic partner: Last Name, First Name, Gender, Date of Birth, Social Security No., Relationship.

**You must also attach to this form** a true copy of your legally recorded marriage certificate or fully executed and notarized same-sex domestic partnership papers (i.e., Declaration of Same-Sex Domestic Partnership for Enrollment or Eligibility, Affidavit of Domestic Partnership, Registration of Domestic Partnership, Affidavit of Dependency for Tax Purposes), and a true copy of your spouse or partner's birth certificate.

## SECTION II: DEPENDENT INFORMATION (CONTINUED)

*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 1-800-562-4690 for instructions.*

**Dependent Children:** The following information must be provided about your dependent children: Last Name, First Name, Gender, Date of Birth, Social Security No., Parental or Guardian Relationship and whether the child is a full-time Student or is Disabled.

For each child listed you must attach a true copy of the recorded birth certificate(s)\* for your natural child, or a copy of the adoption papers issued by the court, or a letter of placement by an adoption agency, or the guardianship papers, and/or a copy of a qualified medical child support order (if the child is not dependent upon you for support or maintenance but has a right to health coverage).

If your unmarried child is over age 21 and a full-time student, you must complete an "AFTRA Health Plan Full-Time Student Verification Form" and send it to the Eligibility Department in the AFTRA H&R New York office, along with acceptable documentation (as defined on the form) confirming that your child is enrolled as a full-time student for the current semester. The form is available at [www.aftrahr.com](http://www.aftrahr.com) under the Forms/Health forms/General Health Plan forms tabs, or call Participant Services at 1-800-562-4690 to request a form.

If your unmarried child is over age 21 and continues to be dependent upon you due to a physical or mental disability, please attach a letter from the child's treating physician describing the nature of the disability. Additional information may be requested in a form satisfactory to AFTRA H&R.

*\*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 name) to add your natural child to coverage for a period of 90 days from the date of birth while you obtain a recorded birth certificate.*

## SECTION III: GROUP LIFE INSURANCE INFORMATION

**Beneficiary Designation:** You must list at least one beneficiary. You may list more than one if you wish. The following information must be provided about each beneficiary: Last Name, First Name, Social Security No., Relationship (to you), and Mailing Address. Also, be sure to indicate the share to be paid to each beneficiary. The total of all shares must equal 100%. *(If you require additional space, please attach a separate piece of paper.)*

AFTRA H&R should be notified about your death in writing and receive a copy of the recorded death certificate within 90 days, or as soon as reasonably possible. For additional important information about the life insurance benefit and how to notify AFTRA H&R, visit [www.aftrahr.com](http://www.aftrahr.com) or call Participant Services at 1-800-562-4690.

## SECTION IV: ALTERNATIVE HEALTH COVERAGE INFORMATION

**Alternative Health Coverage Information:** The AFTRA Health Plan includes a coordination of benefits (COB) provision for enrolled participants covered under another health insurance policy or group health plan. COB is a method of determining which health insurer or group plan pays your claims first (i.e., primary) and which pays second (i.e., secondary) when you have multiple sources of coverage. You have an obligation to advise AFTRA H&R about the existence of any alternative health insurance policy or group 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 must file a claim with each insurer or group plan that covers you and/or your dependent(s).

**If you qualify for coverage under both the AFTRA Health Plan and the Screen Actors Guild – Producers Health Plan (SAG-PHP), it is important for you to know that the plan in which you have qualified continuously for coverage the longest is primary and the other plan is secondary.** If you qualify for primary coverage with SAG-PHP and secondary coverage with the AFTRA Health Plan, and you elect not to pay the SAG-PHP premium but do pay the AFTRA Health Plan premium, you will have no coverage with SAG-PHP and the AFTRA Health Plan only will pay your claims from the secondary position (i.e., we will pay a reduced percentage of the allowable benefit due on your claims as if you had paid the premium for SAG-PHP primary coverage).

Other rules apply if you have qualified continuously for coverage under both the SAG-PHP and the AFTRA Health Plan for the same period of time. Please call Participant Services at 1-800-562-4690 for additional information.

## SECTION V: DECLARATION AND AUTHORIZATION

You must sign and date this section. If you are a minor, you and your parent or guardian must sign and date this section. AFTRA H&R will be unable to process an Enrollment Form if this section is not properly signed and dated.

**AFTRA HEALTH PLAN  
PERFORMER ENROLLMENT FORM**

Please read the instructions on pages 1 & 2 before completing the Enrollment Form.

**SECTION I: PERFORMER INFORMATION**

Social Security No. \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_

Alternate Tax ID No. (if applicable, see instructions page 1) \_\_\_\_\_ Alternate Tax Name \_\_\_\_\_

**Legal Name**  (Check the box if this is your preferred name for correspondence.)

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

**Professional Name** (if different from Legal Name)  (Check the box if this is your preferred name for correspondence.)

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

**Mailing Address and Other Contact Information** Are you providing information for your  **Primary Residence** or your  **Representative's Office**?

If you checked Representative's Office (i.e., agent, business manager, attorney, etc.), then enter:

Representative's Name \_\_\_\_\_

Representative's Company Name (if applicable): \_\_\_\_\_

No. and Street \_\_\_\_\_ Apt/Unit/Suite/Floor \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Area Code and Telephone No. \_\_\_\_\_  Home  Mobile  Work  Representative's No.

E-mail Address \_\_\_\_\_

**Marital Status** (Please check one):  **Single**  **Married**  **Same-Sex Domestic Partnership**

Date of marriage or same-sex domestic partnership (MM/DD/YYYY): \_\_\_\_\_

**SECTION II: DEPENDENT INFORMATION**

**Dependent Information:** List dependents you wish to enroll in the AFTRA Health Plan including your legal spouse, same-sex domestic partner, unmarried children age 21 and under who are dependent upon you for maintenance and support, unmarried children who are full-time students ages 21 through 23, unmarried children of any age dependent upon you due to disability, or children recognized under qualified medical child support orders. See the completion instructions for this section on pages 1 and 2 for required documentation.

Last Name/First Name/MI	Gender (M/F)	Date of Birth MM/DD/YYYY	Social Security No.	Relationship*	Full-Time Student (Y or N)	Disabled Child (Y or N)

\*Relationship means marital/partnership, parental or guardianship status, i.e., legal spouse (opposite or same-sex), same-sex domestic partner, natural child, step child, adoptive child, legal guardian or responsibility under a qualified medical child support order.

**SECTION III: GROUP LIFE INSURANCE INFORMATION**

**Beneficiary Designation:** A \$30,000 life insurance benefit may be available to the beneficiary or beneficiaries you name below under the terms of the AFTRA Health Plan. If more than one beneficiary is named the sum of the benefit shares must equal 100%. A separate form must be completed to designate beneficiaries for AFTRA Retirement Plan benefits. See the completion instructions for this section on page 2 for additional important information.

**Beneficiary (or beneficiaries)**

Last Name/First Name/MI \_\_\_\_\_ Social Security No. \_\_\_\_\_

Relationship \_\_\_\_\_ Mailing Address \_\_\_\_\_ % of Benefit\* \_\_\_\_\_

Last Name/First Name/MI \_\_\_\_\_ Social Security No. \_\_\_\_\_

Relationship \_\_\_\_\_ Mailing Address \_\_\_\_\_ % of Benefit\* \_\_\_\_\_

**Sum must = 100%\***

**SECTION IV: ALTERNATIVE HEALTH COVERAGE INFORMATION**

1) Are you or any of your dependents qualified to enroll in the Screen Actors Guild – Producers Health Plan?  Yes  No

2) Are you or any of your dependents enrolled in the Screen Actors Guild – Producers Health Plan?  Yes  No

3) Are you or any of your dependents enrolled in another health insurance policy or group health plan?  Yes  No

If you answered "Yes" to questions 2 and/or 3 above, 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 \_\_\_\_\_

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

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

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

**SECTION V: 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 misinformation 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 misinformation provided on this form or its attachments.

**Performer Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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

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