

SECTION II: PATIENT INFORMATION CONTINUED

Details of accident or work injury:

Name of Plan providing benefits related to accident or work injury:

Insurer/Plan Name _____
Policy/Plan No. _____ Policy/Plan Effective Date (MM/DD/YYYY) _____

SECTION III: OTHER COVERAGE INFORMATION

- 1) Is the participant or dependent qualified to enroll in the Screen Actors Guild – Producers Health Plan? Yes No
- 2) Is the participant or dependent enrolled in the Screen Actors Guild – Producers Health Plan? Yes No
- 3) Is the participant or dependent enrolled in another health insurance policy or group health plan? Yes No

If you answered “Yes” to any of the questions 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.)*

To facilitate claims processing, please also attach a copy of the front and back of the ID card for the other health plan.

Name of Covered Individual _____ Policy/Plan No. _____
Plan Name _____ Policy Effective Date (MM/DD/YYYY) _____
Insurer Name _____ Insurer Telephone No. _____
Insurer Address _____

Name of Covered Individual _____ Policy/Plan No. _____
Plan Name _____ Policy Effective Date (MM/DD/YYYY) _____
Insurer Name _____ Insurer Telephone No. _____
Insurer Address _____

SECTION IV: DECLARATION AND AUTHORIZATION

Any person who knowingly and with intent to defraud files a statement of claims containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

I certify that all the information provided on this form and in any attached document is accurate and complete. I authorize the release of all information needed for the purpose of processing this claim.

Participant’s Signature _____ **Date (MM/DD/YYYY)** _____

SECTION V: PARTICIPANT’S ASSIGNMENT (OPTIONAL - READ CAREFULLY BEFORE SIGNING)

I hereby authorize the AFTRA Health Plan to pay directly to the physician or other providers the benefits to which I am entitled to the extent of their interest as established by the attached bill(s).

Provider Name _____
Participant Name _____