

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.) Failure to notify AFTRA H&R promptly may affect your or your dependent's right to coverage. For information about AFTRA H&R's written notice and documentation requirements for adding or removing dependents, view the instructions that follow. You also may visit www.aftrahr.com to review the requirements ("Life events" | "Documentation requirements") and to refer to the 2005 AFTRA Health Plan Summary Plan Description and subsequent Benefits Updates ("Health Fund" | "Health Plan SPD"). If you have additional questions, call Participant Services at (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 ("Forms" | "Health forms"), or call Participant Services at (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

SECTION II: DEPENDENT INFORMATION (CONTINUED)

Partnership, Registration of Domestic Partnership, Affidavit of Dependency for Tax Purposes), and a true copy of your spouse or partner's birth certificate.

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.

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 has an impairment that is certified in writing by the child's treating physician and is expected to result in death or last (or be expected to last) for a continuous period of at least 12 months.

You also must certify that none of the adult children you wish to enroll in the AFTRA Health Plan is eligible to enroll in other employer-sponsored health coverage (other than coverage through a parent).

For each child listed you must attach documentation that establishes your relationship to the child. The following documents are acceptable evidence: a true copy of the recorded birth certificate* for your biological child; a copy of the adoption papers issued by the court for your adopted child (or a letter of placement by an adoption agency if you have custody of a child during the waiting period before an adoption becomes final); a copy of the recorded birth certificate and your legally recorded marriage certificate to the child's parent if you are adding a stepchild; or proof that a child was officially placed under your supervision in foster care by a governing authority.

If your unmarried child is over age 26 and continues to be dependent upon you due to a physical or mental impairment, please attach a letter from the child's treating physician certifying the nature of the impairment, the date of onset and the prognosis.

**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 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 must 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, review the 2005 AFTRA Health Plan SPD and subsequent *Benefits Updates*, or call Participant Services at (800) 562-4690.

SECTION IV: ALTERNATE HEALTH COVERAGE INFORMATION

Alternate 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 alternate 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 as a secondary payor (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 review the 2005 AFTRA Health Plan SPD and subsequent *Benefits Updates*; visit our Web site at www.aftrahr.com or call Participant Services at (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; children under age 26, excluding adult children who are eligible to enroll in other employer-sponsored coverage (other than through a parent); or unmarried children age 26 or older who are dependent upon you due to an impairment. 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*	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, biological child, stepchild, adopted child or foster child.

Please confirm below that the above adult children are not eligible to enroll in other employer-sponsored group health coverage.

I certify that any adult children listed above are not eligible to enroll in employer-sponsored health coverage (other than coverage of a parent). Yes No

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: ALTERNATE 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, to the extent permitted by law.

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.