

AFTRA Health & Retirement Funds

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Senior Citizen Health Program Request Form

This form should be completed by any AFTRA Health Plan Participant that wishes to enroll in the Senior Citizen Health Program, Individual or Family Plan. Please keep in mind that your eligibility for Individual Plan or Family Plan coverage under the Senior Citizen Health Program is based on your Qualifying Years and Covered Earnings as described in the AFTRA Health Fund Summary Plan Description.

Participant Information:

Name: _____ SSN: _____

Mailing Address: _____

Telephone Number: _____

Email address: _____

Spouse Information:

*As with all of your personal health information, your spouse's SSN will be held under the Plan's strict privacy policies as set forth in the Plan's Privacy Notice which was previously sent to you. It can also be found on the AFTRA H & R website, www.aftrahr.com.

Name: _____ SSN: _____

Date of Birth: _____

Certification Request:

I request that you enroll me in the AFTRA Health Fund Senior Citizen Health Program.

Participant Signature

Date