

COMPLETION INSTRUCTIONS

The AFTRA Health Plan's Senior Citizen Health Program is a Medicare supplement option available to Medicare-eligible performers who:

- Have reached age 65; and
- Meet the minimum qualifying years requirement based on their history of AFTRA-covered earnings; and
- Do not have sufficient covered earnings during four consecutive quarters to qualify them for *active coverage* under the Plan.

See the AFTRA Health Plan Summary Plan Description (SPD) available at www.aftrahr.com or contact Participant Services at (800) 562-4690 if you have questions about your qualification for the Senior Citizen Health Program.

The Senior Citizen Health Program provides coverage which complements your benefits under Medicare Parts A (hospital insurance) and Part B (medical insurance). This means that Medicare will pay its benefit for covered expenses first and the Senior Program pays its benefit second. If you have not already applied for both Medicare Part A and Part B, you should do so as soon as possible. It is important for you to note that if you enroll in a Medicare Advantage Plan (Medicare Part C), you cannot be covered under the Senior Program. In addition, if you enroll in a Medicare Prescription Drug Plan (Medicare Part D), the Senior Program will not provide any prescription drug coverage.

To apply for Senior Citizen Health Program benefits, please provide the information requested on the reverse side of this form, and return it with any necessary documentation of dependent status (see below) to:

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

Once AFTRA H&R receives your completed Senior Citizen Health Program Enrollment Form and any required documentation, we will send you an invoice for the premium due. You have 30 days from the date of the invoice to pay the required premium. *Please note that you cannot be covered under the Senior Program until we receive your completed Enrollment Form, any required documentation and the premium due.*

Under the Senior Citizen Health Program, you may choose to purchase coverage for one or more dependents at the time of your initial enrollment. You must make the election to enroll any dependents that you would like to cover at the time your own coverage first becomes effective. After the initial enrollment, a dependent may only be added if there is a qualifying event, such as acquiring a new spouse or an involuntary change in employment that causes a dependent to lose his or her coverage. (Preventive dental benefits are provided for Senior Program participants, but not their dependents.)

If you are enrolling dependents that are not already covered under the active Health Plan, please be sure to include documentation verifying their dependent status (e.g., copy of your Marriage Certificate, Birth Certificates for children, etc.). For further information about required documentation, please visit www.aftrahr.com ("Life events" | "Documentation requirements"), or contact Participant Services at (800) 562-4690.

If you are receiving an AFTRA Retirement Plan pension, you can have your Senior Citizen Health Program premium deducted from your monthly pension benefit. If you wish to elect this option, please complete the appropriate section on this application. You will be required to pay the first premium by check, but future premiums will be deducted from your pension.

If you have qualified for 15 years of coverage as an active participant under the AFTRA Health Plan based entirely on earnings¹, then once you are enrolled the Senior Citizen Health Program, a \$5,000 death benefit may be paid to a designated beneficiary in the event of your death. If you meet the qualification of 15 years of active coverage, please designate a beneficiary for the Senior Program Death Benefit on the appropriate section of this application.

Information about the AFTRA Health Plan and participation requirements is available at www.aftrahr.com.

¹Periods of Senior Program coverage, Early Retiree Program coverage, COBRA coverage, coverage as a spouse or other dependent, or coverage extended because of disability do not count towards this requirement.

**SENIOR CITIZEN HEALTH PROGRAM
ENROLLMENT FORM**

PLEASE READ THE INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM BEFORE PROVIDING THE INFORMATION REQUESTED BELOW:

PERFORMER INFORMATION

I request that I be enrolled in the AFTRA Health Plan Senior Citizen Health Program:

(Please check the name that you prefer we use in routine correspondence)

Legal Name _____ **Social Security No.** _____

Professional Name (if different from Legal Name) _____ **Date of Birth** _____

Mailing Address

Telephone Number _____ E-mail Address _____

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 who do not qualify for employer-sponsored coverage through their own employment, or unmarried children of any age dependent upon you due to a disability. See the completion instructions for this section 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.

If you receive an AFTRA Retirement Plan pension benefit, do you want AFTRA H&R to deduct your Health Plan premium from your monthly pension payment? Yes No

BENEFICIARY INFORMATION

Last Name/First Name/MI _____ Social Security No. _____

Relationship _____ Mailing Address _____

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 understand that if I elect Medicare Part C (Medicare Advantage Plan), I will not qualify for the Senior Citizen Health Program, and I agree to notify AFTRA H&R in writing should I elect a Medicare Part C plan. I also understand that if I elect Medicare Part D (Medicare Prescription Drug Plan), I will not qualify for prescription drug coverage under the Senior Citizen Health Program, and I agree to notify AFTRA H&R in writing should I elect Medicare Part D coverage. I 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 _____