

COMPLETION INSTRUCTIONS

Please review the instructions below to learn how a full-time employee becomes enrolled in the AFTRA Health Plan as a staff performer.

Who Qualifies as a Staff Performer

The AFTRA Health Plan defines a staff performer as a full-time employee (employed for the performance of AFTRA-covered work) of a radio or television station or network that makes contributions to the Health Plan under a collective bargaining agreement. A staff performer qualifies to enroll in the Health Plan on the first day of the month after 30 days of full-time employment with a contributing employer. Staff performers whose scheduled annual salary is at least \$10,000 but less than \$30,000 qualify for individual coverage under the Health Plan. Staff performers whose scheduled annual salary is \$30,000 or more qualify for family coverage.

How a Staff Performer Becomes Enrolled for Coverage

The following steps are required to enroll a qualified full-time employee as a staff performer:

- The Employer Request for Staff Performer Coverage Form (see reverse) must be completed by a representative of the contributing employer;
- A Performer Enrollment Form – which is available at www.aftrahr.com or by calling Participant Services at (800) 562-4690 – must be completed by the performer and submitted along with the required documentation of dependent status (marriage certificate, birth certificate, etc.) to enroll any dependents; and
- The premium must be paid in full by the due date on the invoice.

The completed forms and required information must be submitted to AFTRA H&R at the following address:

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

To expedite the enrollment process, please send the completed Employer Request for Staff Performer Coverage together with a Performer Enrollment Form completed by the staff member. If AFTRA H&R receives the Employer Request for Staff Performer Coverage Form before the Performer Enrollment Form, AFTRA H&R will contact the performer at the phone number or address provided on the reverse side to obtain the remaining required information. Once AFTRA H&R receives the completed Employer Request for Staff Performer Coverage and Performer Enrollment Forms along with all required documentation, the performer will be mailed an invoice for the amount of the premium due. The performer will be given 30 days from the date of the invoice to pay the required premium.

When Employment Terminates

The AFTRA Health Plan provides that staff performers will continue to qualify for coverage as long as they maintain full-time employee status as described above. If an employee discontinues full-time work as a staff performer before being enrolled in the Plan for five consecutive years, qualification for coverage will end on the last day of the calendar quarter following the quarter in which full-time employment terminates. If the performer was continuously enrolled in the Plan for five or more consecutive years when full-time employment terminates, coverage will end on the last day of the last coverage period for which the performer qualifies based on earnings. The performer and any covered dependents whose coverage ends will be offered the opportunity to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) provided the application is received within 60 days from the date active coverage terminates.

COBRA requires employers to notify a group health plan within 30 days of an employee being terminated or having a reduction in hours of employment. AFTRA H&R depends upon prompt notification from radio or television stations or networks within this 30 day period if it is to provide timely notice of COBRA continuation coverage rights to staff performers (and their dependents, if any) who will lose active Health Plan coverage due to a change in their full-time employment status.

If you have any questions, please contact Participant Services at (800) 562-4690.

**EMPLOYER REQUEST FOR
STAFF PERFORMER COVERAGE**

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

EMPLOYER INFORMATION

I request that the following employee be qualified for AFTRA Health Plan coverage as a full-time staff performer

Employer Name _____

Employer Mailing Address _____

EMPLOYEE INFORMATION

Employee Name _____ **Social Security No.** _____

Date of Birth _____ **Gender** Male Female

Employee Mailing Address _____

Telephone Number _____ **E-mail Address** _____

Date Began Full-Time in AFTRA-Covered Position _____

Annual Salary as of Above Date _____

Position Title _____

I certify that all the information provided on this form and in any attached documents is accurate and complete. I understand that as a representative of the contributing employer, I must notify AFTRA H&R within 30 days of the date this performer's status as a full-time employee changes.

Name of Employer Representative *(Please print)* _____

Position Title _____

Telephone Number _____ **E-mail Address** _____

Signature _____ **Date** _____