Participant: Coordination of Benefits Form

SAG·AFTRA HEALTH PLAN

Instructions

Complete this form providing details for any other health coverage you have so we can determine your order of coverage. The Plan uses this information to determine which plan pays benefits first (primary), next (secondary), and even third.

You'll receive additional forms from HMS to document information for your dependents enrolled in the Plan. There are separate forms for your dependent spouse and children, if applicable. You can complete the information on the HMS website or use the forms they mail to you.

If any information on this form changes, a new form **must be submitted within 30 days.**

HOW TO SUBMIT THIS FORM

Log in to your Benefits Manager to complete your form online at: sagaftraplans.org/login

Or

Mail your completed form to:
SAG-AFTRA Health Plan
PO Box 7830
Burbank, CA 91510-7830

Note: if you have already returned a completed form to the Plan, please disregard.

Participant

LAST NAME	FIRST NAME	MIDDLE NAME	PHONE NUMBER ( )	PARTICIPANT ID (HCID)

1. Aside from your SAG-AFTRA Health Plan and/or Medicare, do you have coverage with another health insurance plan?

☐ NO — Skip to Question 2

☐ YES — Select a policy type: ☐ Group Policy ☐ Private/Individual Policy

COVERAGE STATUS	LEVEL OF COVERAGE	EFFECTIVE DATE
☐ Active ☐ Retiree ☐ COBRA	☐ Family ☐ Individual	

HEALTH PLAN NAME	PHONE NUMBER ( )	MEMBER NAME

TYPE OF COVERAGE	POLICY NUMBER
☐ Medical/Hospital ☐ Rx ☐ Dental ☐ Vision ☐ Mental Health	

LIST OF FAMILY MEMBERS COVERED:

2. Do you qualify for coverage with any other entertainment industry health plan for which you have not taken the coverage?

	POLICY NUMBER	QUALIFIED START DATE	MEMBER NAME	ACTIVE OR RETIRED
DGA HEALTH PLAN ☐ NO ☐ YES				
EQUITY-LEAGUE HP ☐ NO ☐ YES				
MPI HEALTH PLAN ☐ NO ☐ YES				
WGA HEALTH PLAN ☐ NO ☐ YES				

I certify under penalty of perjury that to the best of my knowledge all information provided on this document is true, correct and complete. I acknowledge that it is fraudulent to knowingly fill out this form with any information that is false.

SIGNATURE OF PARTICIPANT DATE

Questions? Please call us at (800) 777-4013.