SAG·AFTRA
HEALTH PLAN

3601 W. Olive Ave., Burbank, CA 91505
Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
P (800) 777-4013 • F (818) 953-9880
www.sagaftraplans.org/health

Enrollment Materials Checklist

To enroll in SAG-AFTRA Health Plan coverage, complete the following SAG-AFTRA Health Plan materials:

☐ **Employer Request for Staff Coverage**

- Required: Employers should submit this form to notify the Plan of participant's employment start date and requested coverage.

☐ **Participant Information Form**

- Required: participant should submit this form to provide basic information to the Plan.

☐ **Designation of Beneficiaries Form**

- Required: this form is used to designate beneficiaries in the event of participant's death.

☐ **Dependent Enrollment Form**

- Optional: participant should complete this form to add dependent coverage. This can also be done online at https://my.sagaftraplans.org/health.

☐ **Authorization for Release of Health Information Form**

- Optional: participant should complete this form to designate someone third parties to communicate with the Plan on their behalf. Examples include business managers, family members, or employer/union representatives.

☐ **Automatic Premium Payments Form**

- Optional: participant should submit this form in order for the Plan to deduct health premiums automatically from a checking or savings account.

☐ **Premium Payroll Deduction Agreement**

- Required: Employer should complete this form in order to have your premiums taken directly from employee's paycheck on a pre-tax basis and sent directly to the Plan.

Return forms by mail or email to:

Rick Sommers
SAG-AFTRA NY Local
1900 Broadway/5th floor
New York, NY 10012
Rick.Sommers@sagaftra.org

Arda Dabbaghian
SAG-AFTRA Health Plan
3601 West Olive Ave., Suite 200
Burbank, CA 91505
stationstaff@sagaftraplans.org

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Employer Request for Staff Coverage

A "staff participant" is a full-time employee of a radio or television station or network that contributes to the SAG-AFTRA Health Plan under a collective bargaining agreement. A staff participant qualifies to enroll in the Plan on the first day of the month after 30 days of full-time employment with a contributing employer. Full-time staff whose annual salary is $33,000 or more qualify for Plan I. Full-time staff whose annual salary is between $17,000 and $33,000 qualify for Plan II coverage. Both Plan I and Plan II include family coverage.

How a qualified full-time employee enrolls in the Plan

- A contributing employer's representative completes the Employer Request for Staff Coverage Form (see back of this document).
- The participant completes and submits a Participant Information Form – available at www.safaftraplans.org/health or by calling (800) 777-4013. If enrolling dependents, the participant must also include acceptable documentation (recorded marriage or birth certificate, etc.).
- The participant must pay premiums in full and on time.

Send the completed forms and documentation to the Plan at the mailing address at the top of this page. The information can also be emailed to stationstaff@sagaftraplans.org or faxed to (818) 973-4465. To save time, please send the completed Participant Information Form when you send the Employer Request for Staff Coverage Form.

After the Plan receives your forms and documentation, you will receive an invoice for the premium due. You will then have 30 days from the date of the invoice to make the premium payment. Premiums can be paid by mail, online in your Benefits Manager at www.sagaftraplans.org/health, or by signing up for automatic premium payments.

When employment ends

Staff participants continue to qualify for Plan coverage as long as they maintain full-time employee status. If an employee discontinues full-time work as a staff participant before being enrolled in the Plan for five consecutive years, qualification for Plan coverage will end on the last day of the calendar quarter following the quarter in which full-time employment ended. If the participant is enrolled continuously in the Plan for five or more consecutive years when full-time employment ends, coverage will end on the last day of the last qualified coverage period. The participant and any covered dependents whose coverage ends will then be offered the opportunity to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), provided the Plan receives that participant's COBRA application within 60 days from the date active coverage ended.

COBRA requires employers to notify a group health plan within 30 days of an employee's employment termination or reduction in hours. The Plan depends on radio/television stations or networks to notify it within this 30 day period so the Plan can inform staff performers of their rights to COBRA continuation coverage when they lose active Plan coverage due to their change of employment status.

Employer Request for Staff Coverage Form

Please read the instructions on the reverse side before providing the information requested below.

Employer information
Employer name:
Station call letters:
Station address (street):
Station address (city, state, zip):

Employer representative	
Name:	Title:
Phone:	Email:

Employee information		
Employee name (first, middle, last):		
Date of birth (MM/DD/YYYY): / /	Gender: ☐ Male ☐ Female	Social Security number: — —
Employee's annual salary (as of signature date below):	Employee's position title:	Date covered position began: / /
Employee is: ☐ New Hire ☐ Transferring from corporate plan ☐ Other _____		
Premium payroll deduction: ☐ Yes ☐ No If Yes, start date: / /		
Employee mailing address (street):		
Employee mailing address (city, state, zip):		
Phone:	Email:	

I certify that all the information provided on this form and on any attached documents is accurate and complete. I understand that the contributing employer must notify the SAG-AFTRA Health Plan within 30 days if the participant's status as a full-time employee changes.

_____ / /

Employer signature Date

Email to: stationstaff@sagaftraplans.org

Office use only

Coverage start: _____

☐ Plan I ☐ Plan II

SAG-AFTRA HEALTH PLAN
SAG-PRODUCERS PENSION PLAN

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Participant Information Form

Please update us every time you change your address, phone number and/or email. The SAG-AFTRA Health Plan and the SAG-Producers Pension Plan share this information if you are a participant of both. For more information about eligibility requirements, please visit www.sagaftraplans.org.

Please complete and sign below

<table>
<tr><td colspan="2">Date of birth (MM/DD/YYYY):
/ /</td><td colspan="2">Gender:
☐Male ☐Female</td><td>Social Security number:
- -</td></tr>
<tr><td colspan="5">Legal name (first, middle, last):</td></tr>
<tr><td colspan="5">Professional name (first, middle, last):</td></tr>
<tr><td colspan="5">Please indicate which name you prefer us to use when sending correspondence:
☐ Legal ☐ Professional</td></tr>
<tr><td colspan="5">Address 1:</td></tr>
<tr><td colspan="5">Address 2:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td><td colspan="2">Country:</td></tr>
<tr><td colspan="2">Home phone:</td><td colspan="3">Mobile phone:</td></tr>
<tr><td colspan="2">Email:</td><td colspan="3">Alternate email:</td></tr>
</table>

This is a confidential legal document and must be signed by the participant before it can be accepted as a valid record. If the participant is a minor, the parent or legal guardian must sign this document.

Signature _____ Date _____

Relation to participant (if participant is a minor) _____

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Designation of Beneficiaries Form

Use this form to designate the beneficiaries of your SAG-AFTRA Health Plan (Plan) benefits in the event of your death. You may choose anyone to be your beneficiary, and you may change your designation at any time. This is a confidential legal document, which the participant or legal guardian of the participant must sign.

About you:

First and last names:	Date of birth (MM/DD/YYYY): / /	SSN: - -

Instructions: You must list at least one primary and one secondary beneficiary. (See sample on reverse side.) You cannot list yourself as a beneficiary. Be sure to indicate the share to be paid to each beneficiary. Benefits will not be paid to any secondary beneficiary unless all primary beneficiaries are deceased. For example, if you name two primary beneficiaries and one of them dies, the surviving primary beneficiary will receive all of the benefits upon your death even if you name one or more secondary beneficiaries.

You must complete a separate *Designation of Beneficiaries Form* from the SAG-Producers Pension Plan and/or the AFTRA Retirement Plan for possible pension benefits that may be payable upon your death.

Primary beneficiary — If you have additional primary beneficiaries, please list them on the back of this form.

Name:	Relationship:	Share of benefit: %
Address:		
Email:	Phone:	
Name:	Relationship:	Share of benefit: %
Address:		
Email:	Phone:	

Secondary beneficiary — If you have additional secondary beneficiaries, please list them on the back of this form.

Name:	Relationship:	Share of benefit: %
Address:		
Email:	Phone:	
Name:	Relationship:	Share of benefit: %
Address:		
Email:	Phone:	

Signature of participant or legal guardian

Date

Sample beneficiary designation

Primary beneficiary

NAME MARY SMITH	RELATIONSHIP MOTHER	SHARE OF BENEFIT 100%	
ADDRESS 12345 ANY STREET, ANY TOWN, STATE, ZIP CODE			
EMAIL MARYSMITH@MARYSMITH.COM	PHONE NUMBER (800) 777-4013		
NAME N/A	RELATIONSHIP N/A	SHARE OF BENEFIT N/A	
ADDRESS N/A			
EMAIL N/A	PHONE NUMBER N/A		

Secondary beneficiary

NAME NANCY WHITE	RELATIONSHIP FRIEND	SHARE OF BENEFIT 50%	
ADDRESS 12345 ANY STREET, ANY TOWN, STATE, ZIP CODE			
EMAIL NANCYWHITE@NANCYWHITE.COM	PHONE NUMBER (800) 777-4013		
NAME JAMES SMITH	RELATIONSHIP BROTHER	SHARE OF BENEFIT 50%	
ADDRESS 12345 ANY STREET, ANY TOWN, STATE, ZIP CODE			
EMAIL NANCYWHITE@NANCYWHITE.COM	PHONE NUMBER (800) 777-4013		

Additional beneficiary designation (optional)

Additional primary beneficiary

Name:	Relationship:	Share of benefit: %
Address:		
Email:	Phone:	
Name:	Relationship:	Share of benefit: %
Address:		
Email:	Phone:	

Additional secondary beneficiary

Name:	Relationship:	Share of benefit: %
Address:		
Email:	Phone:	
Name:	Relationship:	Share of benefit: %
Address:		
Email:	Phone:	

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New Dependent Form

Please fax to the Participant Eligibility department at (818) 973-4465

Within 60 days of acquiring a new dependent (for example, a new child or spouse), please add them to your Benefits Manager at www.sagaftraplans.org/health or return this completed form to the Plan — even if you do not have the recorded marriage or birth certificate, which you can send later or upload online. Please note that your new dependents will not have health insurance coverage until the Plan has received and approved all required documents and your premium payment. If the amount of your premium changes due to the enrollment of a new dependent, a new billing statement will be sent to you.

Required documentation

- Spouse: Copy of the recorded marriage certificate
- Child: Copy of the recorded birth certificate, adoption, or guardianship papers

Exception: We will accept a copy of the birth certificate from the hospital to add your biological child who is younger than one year of age for a period not to exceed 120 days while you obtain a recorded copy.

Participant name	Date of birth	Health care ID (HCID) number

Please complete the following:

First and last name List new dependent(s)	Gender (M/F)	Date of birth (MM/DD/YYYY)	SSN	Relationship: spouse; biological, step, adoptive or foster parent; or legal guardian	Enroll dependent (Y/N)

NOTE: Upon our receipt of your approved documentation, coverage for your new dependents will begin on the later of the commencement of your eligibility or the date your dependents become eligible.

I have read and understand the rules for new dependents.

Participant signature _____ Date _____

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Authorization for Release of Health Information Form

- Send the completed, signed and dated form to the privacy officer at the mailing address above.
- The SAG-AFTRA Health Plan (Plan) is required to have a separate form signed by each individual covered by the Plan age 18 and over.
- This form does not serve as a change-of-address form.

Participant: _____

Participant Social Security number (SSN): _____ - _____ - _____

Patient (if different than participant): _____

This individual authorizes the release of his/her Protected Health Information (PHI).

(Check only one box): ☐ Participant ☐ Spouse ☐ Dependent (18 or older) ☐ Dependent (under 18)

Current address (street, city, state, zip): _____

_____ Daytime phone

_____ Home phone

_____ Email

1. Health information to be disclosed or used (check only one box)

☐ Any and all information maintained by the Plan

☐ Release only specific information related to ☐ eligibility/enrollment ☐ claims records ☐ claims status

☐ Other (describe the specific health information you authorize the Plan to disclose): _____

2. Health information to be disclosed for the following specific purpose(s):

☐ Medical care

☐ Insurance/eligibility and benefits

☐ Legal investigations or action

☐ At my personal request

3. Name(s) and address(es) of person(s) or organization(s) authorized to receive the information. I understand that after this information is disclosed, federal law might not protect it. More information is on the next page of this form.

_____
Full name Address

_____
Full name Address

4. This authorization shall expire (check only one box)

☐ On: _____(mm/dd/yyyy) (Must be a future date, not the date in the signature line)

☐ Upon the occurrence of the following event related to my health care or to the purpose for which I have authorized the use and/or disclosure described in section 2 above: _____

Important: If no box is checked, this authorization will expire two years after the date when this form was signed.

5. Signature of participant/patient (if not participant)

By signing this authorization, I authorize the Plan to disclose my protected health information (PHI) to the person(s) or organization(s) listed in section 3. I have signed this authorization voluntarily to document my wishes regarding the disclosure of the health information described in sections 1 and 2 of this form, and acknowledge that I have read and understand my rights described in section 7.

_____
Signature of participant, spouse, dependent (age 18 or older) or parent of dependent (if under age 18) Date

6. If a personal representative is executing this form, please provide an explanation and documentation supporting his/her authority to sign on behalf of the participant/patient. ☐ Check if documentation is attached.

_____ Personal representative (print)

_____ Signature of personal representative

_____ Relationship to participant/patient

The *Authorization for Release of Health Information Form* is required for release of protected health information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This form authorizes the SAG-AFTRA Health Plan (Plan) to disclose your health information to the person(s) and/or organizations you designate. If the person(s) and/or organization(s) listed in section 3 are not covered entities subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

7. Your rights regarding this authorization

- Right to revoke. You have the right to revoke this authorization at any time. Your revocation of this authorization must be in writing. To obtain a copy of an *Authorization Revocation Form* you may contact the Plan at the address listed below. Your revocation will not affect the disclosures of your PHI that have already been made according to this authorization to the person(s) and/or organization(s) identified in section 3 of this authorization. I understand that after this information is disclosed, federal law might not protect it.
- Right to receive copy of this authorization. I understand I have the right to receive a copy of this authorization by contacting the privacy officer.
- For an *Authorization Form* or a *Revocation Form* contact: Privacy Officer, SAG-AFTRA Health Plan, P. O. Box 7830, Burbank, CA 91510-7830

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Automatic Premium Payment Form

Enjoy the security of knowing that your premium is paid on time by using our automatic payment option. When you sign up, your premium will be deducted on a recurring basis from a U.S. checking or savings account. If you are on the COBRA program — or have 'senior performers' or 'surviving dependent' coverage — your payments will be deducted monthly on the 25th of the month prior to the due date. If you have 'earned' coverage, your premiums will be deducted quarterly on the 25th of the month prior to the due date.

To get started, register using your Benefits Manager at www.sagaftraplans.org/health and click on "sign up for automatic payments." You can also complete and sign the form on the back; please mail or fax the completed form to the Plan, and be sure to include all of the required bank information. Key points to consider:

- If you are currently covered and are enrolled in automatic payments, you do not need to submit this form or a payment at this time. Your payment will continue to be deducted automatically.
- Completed applications must be received in our office 15 days prior to the premium due date. Enrollment in automatic payments may be delayed if your premiums are not current.
- As long as you are eligible for coverage the Plan will automatically deduct your premiums. This will occur regardless of changes in the premium rate or benefit plan (e.g., going from Plan I to Plan II).
- You will need to complete a new automatic payment application if your coverage is interrupted, or changes from COBRA to 'earned' or from 'earned' to COBRA.
- Advance notification will be sent in the event of any change in your eligibility status or premium rate. You will be charged a fee of $25.00 for a declined automatic payment transaction.
- Cancellation or change in bank account information requires a written request and must be received in our office 15 days prior to the premium due date. We cannot process verbal requests.

If you have questions, call us at (800) 777-4013 or log in to your Benefits Manager at www.sagaftraplans.org/health and use the message center. You can also view your earnings, pay premiums, sign up for Plan emails and more.

Automatic Premium Payment Application

☐ New Applicant ☐ Change *(change in bank or account information)*

Print name of participant or surviving dependent: _____

Participant SSN/HCID: _____ Automatic payment effective date: _____

Mark one box only: ☐ Checking account (attach voided check below) ☐ Savings account

Name of bank: _____

Bank address: _____

Bank account number: _____

Routing number: _____

I, _____
(participant or account holder if not participant)

authorize the SAG-AFTRA Health Plan (Plan) to withdraw the scheduled monthly and or quarterly (whichever is applicable) Plan premium payment from my checking or savings account on approximately the 25th of the month prior to the due date based on the information provided by me on this form. **I further authorize the Plan to adjust this withdrawal to reflect any rate change that may occur.** The Plan's authority is to remain in full effect until the Plan has received written notification from me of its termination or until the Plan has sent me a 10-day written notice of the termination of this agreement.

_____ _____
Participant/surviving dependent signature (required) Date

_____ _____
Account holder signature (required if not participant or surviving dependent) Date

Automatic payment applies to U.S. bank accounts only.

ATTACH VOIDED CHECK

Premium Payroll Deduction Agreement Form

You may choose to have your SAG-AFTRA Health Plan premiums deducted from your wages on a pre-tax basis over the course of a calendar year.

☐ **YES** — please deduct my Plan premiums from my paychecks on a pre-tax basis. By signing and returning this form, I authorize my employer, _____, to withhold the contribution I owe as an enrolled participant in the Plan. I understand these contributions will be withheld for ___ payroll periods during a calendar year.

I agree to reduce my compensation by $_____ (Step #2) pre-tax each pay period for the Plan year, subject to adjustments on a pro-rata basis in the case of a portion of the Plan year. This amount represents a deduction of $_____ (Step #1) per year ("annual election").

I authorize my employer, _____, to increase or decrease automatically this pre-tax compensation reduction if the cost of Plan benefits changes or my premium is increased or decreased due to a "qualifying life change" (i.e. marriage or divorce, birth or death of a dependent, child dependent becoming older than the Plan covers), which I have communicated to the Plan in a timely manner. My authorization for pre-tax deductions will roll over to future Plan years unless I notify the Plan and my employer in writing to cancel.

Step #1 — Calculate your premium rate (Plan I rates shown below)

Individual:	$300 quarterly $1,200 annually
Individual plus one:	$348 quarterly $1,392 annually
Individual plus two or more:	$375 quarterly $1,500 annually

Step #2 — Calculate your payroll deduction

$_____

Divide your premium rate from Step #1 by ___ pay periods (example: $1,680 divided by 24 = $70.00). Enter the amount above.

Note: Although there are _____ pay periods in a year, your annual premium will be deducted over _____ pay periods.

_____ _____

Participant name (print) Participant Social Security or HCID number

_____ ___/___/___

Participant signature Date

☐ **NO** — I do not want to pay my Plan premiums with pre-tax deductions from my paychecks, a choice that has been explained to me. Instead, I will receive quarterly premium invoices from the Plan in the mail, which I will be responsible for paying directly, or I will pay my premiums online in my Benefits Manager at www.sagaftraplans.org/health.

_____ _____

Participant name (print) Participant Social Security or HCID number

_____ ___/___/___

Participant signature Date