I.A.T.S.E. National Health & Welfare Fund:
Dependent Election Form (spouse or dependent child)

Note: Only complete this form if you are already enrolled in coverage (Plan A, C1, C2, C3, C4,Triple S, MRP, RMRP) through the IATSE National Benefit Funds and would like to add a dependent. Please refer to your Summary Plan Description for more details regarding adding dependents.

Please complete the form below and submit a copy of your marriage certificate and/or dependent's birth certificate(s). **In order to switch to family coverage, we must receive your completed form, copies of dependent documents and applicable copayment (copayment applies to Plan C only) within 60 days of birth or marriage or within 60 days after the National emergency is declared lifted by the President, which has yet to be determined, whichever is later**. Please note that coverage for dependent children will extend through the end of the year in which they turn age 26.

Participant Information

Last Name: ____________________First Name: __________________Middle Name:____________

Participant ID# or SSN:________________ Sex: (Circle) M / F Date of Birth: ____ /_____ /_____

E-Mail ________________________________ Telephone #_______________________________

Dependent Information

Spouse:

Last Name: _______________________First Name: _______________________Middle___________

Sex: M / F SSN: ________________________ Date of Birth: _____ /_____ /_____
MANDATORY

Children:

Child Name: _________________Sex: M / F Date of Birth: ____/___ /____ SSN:_______________
MANDATORY

Child Name: _________________Sex: M / F Date of Birth: ____/___ /____ SSN:_______________
MANDATORY

Child Name: _________________Sex: M / F Date of Birth: ____/___ /____ SSN:_______________
MANDATORY

Current Coverage Information

Current Coverage Type: ☐ Single ☐ Family

Current Plan: ☐ A ☐ C1 ☐ C2 ☐ C3 ☐ C4 ☐ Triple S ☐ C-MRP ☐ RMRP

Change in Coverage option

☐ I would like to enroll in family coverage.*

New Plan Type: ☐ A ☐ C1 ☐ C2 ☐ C3 ☐ C4 ☐ Triple S ☐ C-MRP ☐ RMRP

*** If you are enrolled under Plan C, please contact the Fund Office to determine if a payment would be due. This payment must be received along with this form and copy of your marriage certificate or dependent birth certificate(s) or hospital discharge papers. If you are electing Plan C-MRP, a copy of the front and back of your employer or union sponsored group health coverage ID card must be submitted along with a signed MRP-Stand Alone Option Form. Note that to enroll a dependent in Plan C-MRP, such dependent must be enrolled in a group health plan that provides minimum value. You must certify to such coverage below and when you submit any claims for a dependent.**

☐ I would like to add my dependent(s) to the Medical Reimbursement Program, and I certify that the dependent(s) I am enrolling in the Plan C-MRP are enrolled in group health coverage providing minimum value and I will advise the Fund Office immediately if such dependent(s) lose such coverage.

Participant Signature: ________________________________ **Date:** ________________

Please send to:
IATSE National Benefits Fund
P. O. Box 11945,
Newark NJ 07101-4945

If no payment is due, you can send via e-mail to psc@iatsenbf.org or fax to 646-783-7650. Please be sure to call participant services to confirm receipt. If payment is due, make check payable to IATSE National Health & WelfareFund. You can also make a credit card payment by contacting participant services at 1-800-456-3863. A credit card authorization form (which can be found on our website) would need to be on file before payment can be processed. If you have any questions, please feel free to call participant services based on the contact information listed above.