

SCREEN ACTORS GUILD-PRODUCERS HEALTH PLAN

NEW DEPENDENT FORM

FAX to the Participant Eligibility Department at (818) 973-4465

This form is used to add new dependents. However, please be aware that as the Participant **you must be covered in order for coverage to be extended to your dependents.**

DEPENDENT DOCUMENTATION INSTRUCTIONS

You must complete and return this form to the Health Plan within 30-days of acquiring a new dependent, even if you are not in possession of the recorded certificate. Document(s) should be sent to the Health Plan as soon as possible for each of the dependents listed on this form. Coverage will not be extended to your dependent(s) until your paperwork is received and approved. If the amount of your premium payment changes due to the enrollment of a new dependent, a new billing statement will be sent under separate cover.

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 natural child who is younger than one year of age for a period not to exceed 120 days while you obtain a recorded copy.

Please complete the following information:

PARTICIPANT NAME	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER or NSA
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List new dependent(s): (please print)

FIRST & LAST NAME	GENDER (M/F)	DATE OF BIRTH MM/DD/YYYY	SSN	Indicate relation: spouse, natural, step, adoptive or foster parent or legal guardian	Enroll Dependent (Y/N)

Important Note: New dependents will not have coverage unless you, the Participant, are or become eligible, all appropriate documents have been submitted, and the Health Plan has received your required premium payment.

Divorce/Dissolution of Partnership: If you remove a dependent from your coverage due to divorce, dissolution of a qualified same-sex domestic partnership or death, you are required to submit a copy of the final judgment of divorce, termination of domestic partnership form or recorded death certificate to the Health Plan. In the event of divorce or dissolution of same-sex domestic partnership, you must notify the Health Plan within 60 days of the date of divorce or dissolution of your domestic partnership in order to preserve individual self-pay rights for the eligible dependent. **Health Plan expenses incurred by your spouse or same-sex domestic partner from the date of divorce or termination of domestic partnership are not covered by the Health Plan.** You will be billed for expenses paid by the Health Plan from the date of divorce or dissolution of domestic partnership. Please visit www.sagph.org to download a new Beneficiary Designation Form.

I have read and understand all of the rules for new dependents and for cancelling enrollment of current dependents.

PARTICIPANT'S SIGNATURE

DATE

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