Writers' Guild-Industry Health Fund

Terence L. Young, Chief Executive Officer

DEPENDENT ENROLLMENT FORM

To Add, Continue or Reinstate Dependent(s)

Participant Name ___________________________________ Health Fund ID Number _____________________ DOB_______________

Address ____

City ____________________________ State________ ZIP Code____________ Phone (   ) ________________________

Please submit the appropriate documentation needed for each new dependent.

SPOUSE:	A copy of the certified marriage certificate
CHILD:	A copy of the certified birth certificate
ADOPTION, FOSTER CHILD or GUARDIANSHIP:	A copy of the adoption/release or guardian placement documents
SAME SEX DOMESTIC PARNTERSHIP:	A signed Affidavit of Domestic Partnership and any additional documents requested by the Administrative Office. (Please refer to the Same Sex Domestic Partner Information Packet)

New Dependents: The Fund requires a premium of $150.00 per quarter ($50 per month) to cover all of your dependents. If you are adding new dependents, please attach the appropriate documentation, complete the dependent information section and return this form with the appropriate documentation and a check or money order for $150.00 (if applicable) payable to Writers' Guild-Industry Health Fund (Fund).

Continuing Dependents: If you are continuing coverage for your spouse, same-sex domestic partner or dependent children that are between ages 0 and 17; this form **does not** need to be returned. **However, if your dependent children are between the ages of 18 and 26, and they do not have access to health insurance coverage through an employer, this form must be returned in order to continue their coverage**. Please fill in the dependent information section completely; check the appropriate box and sign and return this form.

Reinstating Dependents: If you are reinstating an eligible spouse, same-sex domestic partner or dependent children up to age 26, **this form must be returned**. Please fill in the dependent information section completely. Return this form with the appropriate documentation and a check or money order for $150.00 (if applicable) payable to Writers' Guild-Industry Health Fund.

Premiums are due quarterly and are payable in advance. You will receive subsequent invoices for future premiums due (if applicable). You may pay for more than one quarter at a time.

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DEPENDENT ENROLLMENT FORM

To Add, Continue or Reinstate Dependents

(Please check all that apply)

○ Adding new dependent(s) ○ Continuing dependent(s) ○ Reinstating dependent(s)

Dependent Name	Relationship	DOB	Social Security # required for ALL dependents	My dependent between 18 and 26 does not have access* to health insurance through their employer or their spouse's employer
				Affirmed
				Affirmed
				Affirmed
				Affirmed
				Affirmed
				Affirmed

*Access – denotes that the dependent child is eligible to enroll in, or purchase health coverage through an employer (regardless of the costs of that coverage or the benefits it provides). In addition, eligibility for coverage under a group health plan of the child's spouse's employer constitutes "health insurance coverage through an employer".

By signing this form, I confirm that I understand that:

- I am required to notify the Administrative Office immediately in writing if any dependent child who is at least 18 years old becomes eligible for other employer coverage or if any other statement made herein is no longer true or correct, and
- If I apply for or continued coverage for anyone who is not eligible under the Fund or if I don't notify the Fund of my child's eligibility for other employer coverage, this may be considered fraud or intentional misrepresentation and coverage may be rescinded or terminated to the extent permitted by law. In addition, I agree to be liable for any and all claims presented and paid on behalf of my ineligible dependent(s) by the Fund.

______________________ Signature of Writer

______________________ Printed Name of Writer

______________________ Date