



Producer-Writers Guild of America Pension Plan Writers' Guild-Industry Health Fund



Terence L Young, Chief Executive Officer

CHANGE OF ADDRESS REQUESTS AND THIRD PARTY AUTHORIZATIONS

Attached is the Health Fund and Pension Plan's form for updating your primary and/or secondary address.

The Primary Address Section:

Your PRIMARY address is where we will send all correspondence, including eligibility notifications (including premium billing notices), Explanations of Benefits for claims, Benefit Statements and Pension Plan correspondence. Often, this is your home address, but you may designate a business manager, attorney or other person to receive your correspondence.

The Secondary Address Section:

If you designate your primary address to be a location other than your home address, then we request that you provide your home address as a SECONDARY address. This will be maintained in our files to ensure we can reach you if correspondence sent to your primary address is returned to us by the Post Office.

Authorization to Release Information Forms:

Also enclosed are *two* additional forms. These forms authorize the Health Fund and Pension Plan to disclose your personal information to someone other than you. This may be your spouse, business manager, attorney, or any person of your choosing. ***The Authorization to Release Information form for the Pension Plan*** will remain in effect until you notify the Pension Plan in writing. **The Authorization to Release Information for the Health Fund must be updated annually.** You may wish to note your calendar to be sure you update this form before it expires.

Please feel free to contact Brian Bortoli, Eligibility D.E. Clerk, at the number below, extension 140, if you have any questions regarding these forms.



Producer-Writers Guild of America Pension Plan Writers' Guild-Industry Health Fund



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Address Change Request Form

Please complete and SIGN below. This form CANNOT be processed without your signature.

NAME: _____ ID: WRXA _____

SIGNATURE: _____

Please check one of the following.

This update is for: Pension ONLY _____ Health ONLY _____ Pension AND Health _____

Primary Address

Address: _____	Phone #: _____
C/O: _____	Cell#: _____
City, State Zip: _____	Work#: _____
Email: _____	

Secondary Address (For use ONLY if your primary address is not your home.)

Address: _____	Phone #: _____
C/O: _____	Cell#: _____
City, State Zip: _____	Work#: _____
Email: _____	



Writers' Guild-Industry Health Fund

Terence L. Young, Chief Executive Officer

Authorization For Release of Information

The Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") under federal law requires certain protection and limitations on the disclosure of protected health information (PHI). PHI means information created or received by the Fund that identifies an individual and relates to the individual's past, present or future health, treatment or payment for health care services. PHI may include information regarding enrollment and eligibility.

In many cases, the Privacy Rule limits the Fund's ability to disclose PHI without appropriate authorization. While you are not required to grant an authorization, in certain circumstances, if you do not grant an authorization the Fund cannot disclose your PHI. In order to be valid, the authorization must include the beginning and end dates for the authorization. The authorization must also name the receiving individual/organization and provide a specific description of the information to be disclosed. You may name more than one individual or entity on this agreement only if they may all receive the same information. If each has authority to receive different information, separate authorizations are required.

Page 2 of this authorization requires the signature of the person authorizing the disclosure. Generally, this person must be the subject of the information to be disclosed. Alternatively, the individual's personal representative may authorize the disclosure.

If you wish to authorize disclosure, please carefully review and complete this authorization form and return it to the Fund Office.

I. Information About the Use or Disclosure

I hereby authorize the Fund to disclose certain individually identifiable health information (described in (A) below) to the persons in (B) below for the purposes described in (C) below.

Name: _____ ID Number: _____

(If you are the participant's spouse, Same Sex Domestic Partner, or child, please also list the participant's name: _____)

A. Information to be used or disclosed: _____

Claims Status

Eligibility

Contributions

Other _____

B. Persons/organizations authorized to receive the information: _____

Producer-Writers Guild of America Pension Plan
Writers' Guild-Industry Health Fund

C. Specific purpose of the disclosure: _____

(If you don't want to describe your reasons, you may state "At the request of the individual.")

This authorization is not valid if you do not complete (A)-(C).

This authorization will begin on: _____
Month Day Year

This authorization will expire (choose one):

On _____
Month Day Year

Upon the occurrence of the following event: _____

This authorization shall expire no later than one year from the date of execution.

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Fund Office in writing, but the revocation will not have any effect on any actions the Fund took before the Fund received the revocation.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity without my authorization.
- I understand that I am not required to sign this form to receive my health care benefits, although I must complete all applicable forms for benefits.

III. Copy of this Authorization

- You are entitled to a copy of this authorization. If you do not want the Fund to send you a copy, please check this box .

IV. Signature

Signature of individual or personal representative
(Form *MUST* be completed before signing.)

Date

Printed name of personal representative: _____

Relationship to the individual, including authority for status as representative: _____
(Please provide proof of your status as the individual's personal representative.)

Producer-Writers Guild of America Pension Plan

Terence L. Young, Chief Executive Officer

Authorization to Release Information

The Participant should complete this form, only if the Participant would like to authorize a person or entity to receive Pension information on his/her behalf. *Unless this form is returned (signed and dated by the Participant), information will not be released to any unauthorized third party.* This authorization will remain in effect until such time that the Participant notifies the Administrative Office in writing. A photocopy of this form will be treated as an original, with the full force and power of said original.

SECTION 1 PARTICIPANT INFORMATION	
Please print or type the information below for the Participant.	
NAME	SOCIAL SECURITY NUMBER OR UNIQUE IDENTIFIER

SECTION 2 AUTHORIZED THIRD PARTY INFORMATION		
Please print or type the information below for the third party authorized to receive Pension information on behalf of the Participant.		
NAME OF INDIVIDUAL OR ENTITY	ALL INDIVIDUALS REPRESENTING ENTITY OR INDIVIDUAL NAMES (CHECK ONLY ONE AND LIST, IF APPLICABLE)	
 	<input type="checkbox"/> ALL INDIVIDUALS REPRESENTING ENTITY, OR <input type="checkbox"/> ONLY THE FOLLOWING INDIVIDUALS:	
STREET ADDRESS		
CITY	STATE	POSTAL CODE
TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS
ADDRESS INFORMATION RELATIVE TO PARTICIPANT (PLEASE CHECK THE BOX BELOW TO INDICATE THAT THE ADDRESS ON RECORD FOR THE PARTICIPANT SHOULD BE UPDATED. IF THE BOX IS NOT CHECKED, THEN THE PARTICIPANT'S ADDRESS WILL NOT BE UPDATED.)		
<input type="checkbox"/> UPDATE THE PARTICIPANT'S ADDRESS ON RECORD FOR PENSION PURPOSES TO THE ADDRESS IN THIS SECTION 2.		

SECTION 3 PARTICIPANT'S ACKNOWLEDGEMENT		
I, the Participant, authorize the individual or entity in Section 2 to receive Pension information from the Producer-Writers Guild of America Pension Plan (the "Plan") and that the Plan may act under this authorization upon receipt. I agree to hold the Plan harmless from any claims that may arise against the Plan because of the Plan's reliance on this authorization. I understand that this authorization will remain in effect unless and until I notify the Administrative Office in writing.		
NAME	DATE	SOCIAL SECURITY NUMBER OR UNIQUE IDENTIFIER



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