Election of Medical Reimbursement Program (MRP) as a Stand-Alone Option

I wish to enroll in Plan C-Medical Reimbursement Program (MRP) as a stand-alone option, as described in the Summary Plan Description, pages 26-35. (The Summary Plan Description is available upon request from the Fund Office and on the website, www.iatsenbf.org).

To be eligible for the Plan C-Medical Reimbursement Program (MRP) as a stand-alone option, I understand that I and any dependents I enroll, must have medical coverage with another employer or union sponsored group health plan that provides minimum value under the Patient Protection and Affordable Care Act (ACA). To enroll in this option and waive enrollment in C1, C2, C3, or C4, I must sign this election form and submit proof of other employer or union sponsored group health coverage (copy of front and back of coverage ID card along with a statement from insurer or plan sponsor if my ID card does not specify that it is group coverage). By signing this form, I hereby certify that my and my enrolled dependents (if any) other coverage is through an employer or union sponsored group health plan that provides minimum value under the ACA. In addition, recertification and proof of other employer or union sponsored group health coverage must be submitted annually at the Plan's Open Enrollment period.

I agree to advise the IATSE National Health & Welfare Fund (Fund) in writing immediately if I lose such other coverage.

Participant Name: ___________________________________

Participant ID: ___________________________________

Name of Employer or Union: __________________________

Primary Insurance Company: ________________________________

Your signature below and copy of the front and back of your ID card are required for enrollment in MRP.

Signature _________________________ Date: _________________

You can email this form to psc@iatsenbf.org or fax it to 646-783-7650.