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) or hospital discharge papers. **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**. 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**:** _____

Date of Birth**:** _____ **/**_____ **/**_____ Sex (Circle one): Male / Female / Non-Binary / Unknown

E-Mail _____ Telephone #_____

Dependent Information

Spouse:

Last Name: _____First Name: _____Middle: _____

SSN: _____ Date of Birth: _____/_____/_____
MANDATORY

Sex (Circle one): Male / Female / Non-Binary / Unknown

Children:

Child Name: _____ Date of Birth: _____/_____/_____ SSN: _____
MANDATORY

Sex (Circle one): Male / Female / Non-Binary / Unknown

Child Name: _____ Date of Birth: _____/_____/_____ SSN: _____
MANDATORY

Sex (Circle one): Male / Female / Non-Binary / Unknown

Child Name: _____ Date of Birth: _____/_____/_____ SSN: _____
MANDATORY

Sex (Circle one): Male / Female / Non-Binary / Unknown

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 hospital discharge papers are remitted, a copy of the birth certificate is needed within 6 months from the date of birth to prevent termination.**

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 Election of MRP as a 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 mail to the Fund Office at:

IATSE National Health & Welfare Fund
417 Fifth Avenue, 3rd Floor
New York, NY 10016-2204

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, 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.