ENROLLMENT/COORDINATION OF BENEFITS FORM

Please complete this questionnaire, and return it to the AGVA Welfare Trust Fund, 363 Seventh Avenue, 17th Floor, NY, NY 10001. Once this form has been completed and returned to the Fund office, we will be able to process benefits under your AGVA Welfare Trust Fund coverage.

Performer's Information:

Performer's Name: | Performer's Stage Name *(if any)*:

Mailing Address: | Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

City: | State: | Zip code: | AGVA #

Date of Birth (Month/Day/Year) ______ / ______ / ______ | Home Phone Number: ______ - ______ - ______ | Cell Phone Number: ______ - ______ - ______

Email address:

Current *(or last)* AGVA Employer: | Name of Show, Role & Date of Hire:

The Trustees of the AGVA Welfare Trust Fund have adopted a coordination of benefits rule (COB).
It is mandatory that you answer the following questions*:

Do you have any form of insurance coverage, personally or as a dependent? ☐ NO ☐ YES, *If YES, check all that apply and complete the following:*

MEDICAL COVERAGE/INSURANCE PROVIDED BY OTHER UNIONS:

☐ SAG EFFECTIVE DATE__________ END DATE *(if applicable)*__________

☐ AFTRA EFFECTIVE DATE__________ END DATE *(if applicable)*__________

☐ EQUITY EFFECTIVE DATE__________ END DATE *(if applicable)*__________

☐ **OTHER COVERAGE/INSURANCE:** Type of Coverage *(Medical/Hospital/PPO/HMO, etc.)*:__________

Policyholder Name: __________ Name of Carrier/Claims Administrator: __________

Address and Phone Number of Carrier:__________

Effective Date of Coverage: __________ Policy Group #: __________ ID Number: __________

Waiver of Dental and Optical Benefits: There is no opportunity under this Plan to waive Medical benefits. However, you have the option to decline dental and vision benefits by checking this box. (This will not affect their premium) ☐ *I wish to decline Dental and Optical Benefits.*

Complete the appropriate information in this section if you wish to enroll your Dependent Child(ren). *You must provide the applicable proof of dependent status (copy of certified birth certificate and adoption/placement for adoption papers, or QMCSO) and pay the applicable premiums if you wish to enroll your Dependent Child(ren).*

Reason for Enrollment: ☐Initial Eligibility

☐ New Dependent Child: *Circle One:* Birth Adoption Placement for adoption QMCSO Date of event: __________

Are you declining coverage for child(ren) because of other coverage? ☐ NO ☐ YES

If yes, you must complete information below on each child for whom you are declining coverage in order to retain HIPAA Special Enrollment rights.

☐ Loss of other Group Health Coverage/Medicaid/CHIP (must provide proof)/Date of Termination:__________

	Last Name, First Name and Middle Initial	Sex	DOB	SS#	Declining enrollment because of Other Coverage?	Name of Carrier, Group and ID Number
Child					☐ Yes ☐ No	
Child					☐ Yes ☐ No	
Child					☐ Yes ☐ No	

HIPAA Special Enrollment Rights Under the Plan: If you are declining enrollment for your dependent child(ren) because of other health insurance or group health plan coverage, you may be able to enroll your child(ren) in this plan if your child(ren) lose eligibility for that other coverage (or if the employer stops contributing towards your or your child's other coverage). However, you must complete the above section and provide information on the other coverage at the time you decline enrollment for your child(ren). In addition, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing towards the other coverage). In addition, if you have a new dependent child as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if you (or your child(ren)) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends. You and your dependent child(ren) may also enroll in this plan if you (or your dependent child(ren)) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependent child(ren)) are determined to be eligible for such assistance. Contact the Fund Office for further information.

***Any person who knowingly and with intent to injure, defraud or deceive the Fund, files a statement of claim containing any false, incomplete or misleading information, may be guilty of a criminal act punishable under law, and may be denied benefits.**

PERFORMER'S SIGNATURE__________________ DATE_____/_____/20_____