

LIFE EVENT: NEW CHILD

Getting married. Having a baby. Preparing for retirement. These are the moments in life when your benefits matter most. With that in mind, we have developed the DGA-PPHP Life Events fact sheets to help ensure that you get all of the information you need, when you need it.

If you still have questions, please do not hesitate to contact us at one of the phone numbers at the bottom of this page.

WHAT YOU NEED TO KNOW: HEALTH PLAN

- Unless you are covered under Certified Retiree or Retiree Carry-Over coverage, your new child is eligible for coverage under your Health Plan coverage.
- You have 31 days from the date of birth/adoption to enroll your child under your health coverage. If you miss the 31-day enrollment deadline, you will not be able to add your dependent until your next open enrollment period. We generally include a copy of the dependent enrollment form with this fact sheet. However, if you would like the form faxed, mailed or e-mailed to you, please contact a participant services representative at one of the telephone numbers below. In addition, you may download the form online from the DGA-PPHP Web site (www.dgaplans.org).
- At enrollment, you will be asked to provide a copy of your child's birth certificate or certificate of adoption. If you do not have an official copy at that time, you can provide alternate proof (such as a hospital birth announcement or adoption papers), but an official copy will be required within 6 months.
- One dependent premium payment is due on behalf of all of your dependents (*i.e.* one \$600 payment covers all of your dependents for your entire benefit period). Therefore, if there are no dependents currently enrolled under your coverage, you will be required to pay the dependent premium to cover your new dependent. If you have already remitted the dependent premium for your current dependents, there is no additional premium due. Please note that the dependent premium can be paid in six-month increments (*i.e.* \$300), but not for a lesser period of time.
- If you choose not to initially cover your child under your health coverage because he or she is covered under other health coverage, you will be able to add him or her to your coverage at the time that the other coverage ends. You must notify the Health Plan within 60 days after the other coverage ends and you must provide a copy of your child's Certificate of Coverage from the other health plan.

WHAT YOU NEED TO KNOW: PENSION PLAN

- If you would like to list your new child as a beneficiary, you must file a beneficiary designation form with the Pension Plan. Please note that if you are married and would like your new child to be your primary beneficiary, you will need to obtain spousal consent. We generally include a copy of the beneficiary designation form with this fact sheet. However, if you would like the form faxed, mailed or e-mailed to you, please contact a participant services representative at one of the telephone numbers below. In addition, you may download the form online at the DGA-PPHP Web site (www.dgaplans.org).

The information on this sheet is only a summary of Pension and Health Plan rules. For detailed information, please refer to the Health Plan and Pension Plan Booklets.

COVERING YOUR DEPENDENTS

This section summarizes the information required by the Health Plan to enroll a dependent under your health coverage. If you have already enrolled your dependents under your health coverage and do not wish to make any changes, you do not need to submit additional information.

Coverage for your eligible dependents is effective on the date that your coverage begins, or on the date that you acquire the dependent, whichever is later. Please refer to the Health Plan Booklet for complete details on eligible dependents.

You must submit the following to the Health Plan office in order to cover your eligible dependents under your Health Plan coverage:

- The **Dependent Enrollment Form** (required at initial enrollment or whenever you make a change);
- The required enrollment documentation (required at initial enrollment or whenever you add a dependent); and
- Payment of the dependent premium (for earned coverage) or self-pay premium (for self-pay coverage). Due to all of the factors involved in calculating the additional premium due for a new dependent, you should contact the Health Plan office to determine the amount of premium due in connection with your new dependent. If you would like to pay by check, please make the check payable to **DGA-PRODUCER HEALTH PLAN**. If you would like to pay your premium by credit card or bank account debit, please fill out the **Premium Payment Form**.

The required enrollment documentation is summarized below:

Type of Dependent	Required Enrollment Documentation
Your lawful spouse	Certified marriage certificate
Your same-sex domestic partner	Please contact the Health Plan office and request a domestic partner enrollment package.
Your natural unmarried children up to age 26 and your spouse's natural unmarried children up to age 26, provided they do not have access to other employer-sponsored health coverage other than a parent's group health plan	Certified birth certificate
Your adopted unmarried children up to age 26 or unmarried children up to age 26 dependent upon you for support that are living with you in a normal parent-child relationship, provided they do not have access to other employer-sponsored health coverage other than a parent's group health plan	Adoption or Guardianship documentation
Your unmarried children who are considered totally disabled (please refer to the Health Plan Booklet for details regarding the eligibility of disabled children)	Documentation must be provided showing that: <ul style="list-style-type: none"> • the dependent has been determined to be totally disabled by the Social Security Administration; and • the dependent must be primarily dependent upon you for support and maintenance.

Effective January 1, 2011, to comply with Federal law, the Health Plan increased the maximum age for eligible dependent children to age 26. However, some states (including California) have not yet raised the age limit for taxation of dependent child health benefits. Therefore, participants covering adult dependent children under earned coverage that are older than the age limit for their particular state should be aware that they may be liable for state income taxes on the value of the benefit provided to their child. The Health Plan is awaiting further guidelines from each applicable state. In cases where the Health Plan is required to do so, the Plan will issue tax billings to participants covering dependent children that are over the age limit for their particular state.

DEPENDENT ENROLLMENT FORM

If you are adding or dropping dependents from coverage, please submit this form via mail to the address below or via fax to (323) 866-2399.

Name of Dependent	Social Security #	Date of Birth	Relationship	Sex	Add/Drop
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Same-Sex Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Same-Sex Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Same-Sex Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Same-Sex Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Same-Sex Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Same-Sex Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop

All of the above fields are required information – there may be a delay in enrolling your dependents if any of these fields are left blank.

I hereby certify that any dependent children age 19 or older that I enroll under DGA-Producer Health Plan coverage are not eligible for coverage under any other employer-sponsored health plan, excluding a group health plan sponsored by his or her parent. I will contact the DGA-Producer Health Plan if any of my dependent children age 19 or older become eligible for other employer-sponsored health coverage while they are enrolled as a dependent under my DGA-Producer Health Plan coverage. I understand that I may be held liable for claims overpayments if it is discovered that one of my dependent children was eligible for other employer-sponsored health coverage, excluding a group health plan sponsored by his or her parent, while they were enrolled as a dependent under my DGA-Producer Health Plan coverage.

Participant Signature: X _____

Participant Name: _____

Social Security Number: _____ Daytime Phone Number: _____

PREMIUM PAYMENT FORM

If you would like to pay your premium via credit card or bank account debit, please submit this form via mail to the address below or via fax to **(323) 866-2399**.

Participant Name: _____

Social Security Number: _____ Daytime Phone Number: _____

If you would like to pay your Health Plan premium by credit card or bank account debit, fill out the section below. Please note that the dependent premium can be paid in six-month increments, but not for a shorter period.

Paying by Credit Card
Type of Premium: <input type="checkbox"/> Dependent Premium <input type="checkbox"/> Self-Pay Premium
Amount to Charge:
Charge Type: <input type="checkbox"/> One-Time <input type="checkbox"/> Recurring
Charge Frequency: <input type="checkbox"/> Monthly (self-pay premiums only) <input type="checkbox"/> Quarterly (self-pay premiums only) <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually
Card Type (mark one): <input type="checkbox"/> American Express <input type="checkbox"/> Discover Card <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa
Name of Cardholder:
Card Number:
Expiration Date:
CVV Code (3- or 4-digit number on back of card):

Paying by Bank Account Debit
Type of Premium: <input type="checkbox"/> Dependent Premium <input type="checkbox"/> Self-Pay Premium
Amount to Charge:
Debit Type: <input type="checkbox"/> One-Time <input type="checkbox"/> Recurring
Debit Frequency: <input type="checkbox"/> Monthly (self-pay premiums only) <input type="checkbox"/> Quarterly (self-pay premiums only) <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually
<i>In lieu of providing the information below, you can send a copy of a voided check to the Health Plan along with this form.</i>
Bank Name:
Account Number:
Routing Number:

I hereby authorize the DGA-Producer Health Plan to charge my credit card or debit my bank account for the amount indicated above. If I have elected a recurring transaction, I understand that it will be automatically debited/charged while I and or/my dependents are covered under my Health Plan coverage based on the frequency indicated above. I understand that if my bank/credit card company does not accept the debit/charge, the coverage will be canceled if an alternate form of payment is not made to the Health Plan prior to the expiration of the grace period. I understand that this election is revocable by me at any time and that the Health Plan reserves the right to cancel this agreement at any time by notifying me in writing.

Cardholder Signature: X Date: _____



DIRECTORS GUILD OF AMERICA - PRODUCER PENSION PLANS

8436 WEST THIRD STREET, SUITE 900 LOS ANGELES, CA 90048-4189
(323) 866-2200 OUTSIDE LOS ANGELES AREA (877) 866-2200 FAX (323) 866-2372

GENERAL INFORMATION FOR BENEFICIARY DESIGNATION

The Directors Guild of America - Producer Pension Plans pay death benefits to designated beneficiary(ies) of eligible participants. The Plan Office wants to keep your beneficiary designation up to date to ensure benefits are paid as you would like them to be.

Choose Your Beneficiary

You should designate at least one primary beneficiary for each Plan (Supplemental Pension Plan, Basic Pension Plan). It is advisable to also designate a secondary beneficiary in the event that the primary beneficiary predeceases you or dies before all benefits are paid out. If you list more than one beneficiary for any Plan, be sure to indicate the percentage share to be paid to each.

You may choose a person, estate, organization or trust as your beneficiary. You must provide the Social Security Number and birth date for individuals. If an organization (such as a charity) is designated, provide the name, address and telephone number of the contact person or department at the organization. If a trust is designated:

- ❖ The trust must be valid under state law, or would be but for the fact there is no corpus
- ❖ The beneficiaries of the trust must be identifiable
- ❖ Provide a contact name and phone number

For each Plan, benefits will be paid to the secondary beneficiary(ies) only if all of the primary beneficiaries are deceased. For example, if you name two primary beneficiaries and one of them dies before you do, the other primary beneficiary will receive the entire benefit, and none will go to any of the secondary beneficiaries.

Under certain circumstances, the beneficiary(ies) you list may not be entitled to receive all of the death benefits, as follows:

- ❖ Your surviving spouse will automatically be your primary beneficiary if you are married at the time of death. However, benefits can be paid to someone else if your spouse signs a notarized statement rejecting the spousal benefits.
- ❖ If you have already retired from the Pension Plans, your beneficiary as shown on your retirement papers continues as the designated beneficiary. Joint and Survivor beneficiaries may not be changed. However, if you retired from the Basic Plan under a Ten Year Certain & Life option, you may change your beneficiary by submitting a separate written letter to the Pension Department; spousal consent is required to make any such change. If you have retired from the Supplemental Plan and have post retirement contributions, you may designate a different beneficiary to receive those benefits, provided your spouse has waived the right to the benefits. To change a beneficiary designation on an existing Supplemental Plan benefit being paid by Metlife, you should contact Metlife directly.

- ❖ A Qualified Domestic Relations Order (QDRO) that assigns benefits to a third party supersedes your beneficiary designation. Normally this involves a former spouse who has been granted a portion of your benefits. You should still designate a beneficiary for benefits that are not assigned by the QDRO.

Benefit Amounts

Upon your death, benefits may be payable to your designated beneficiary(ies) from:

- ❖ The Basic Pension Plan
- ❖ The Supplemental Pension Plan

Each Plan has different benefits and eligibility requirements. At any given time you may be eligible for all, some or none of the benefits.

The Basic Pension Plan Death Benefit

The spouse or designated beneficiary of a participant vested in the Basic Plan may be entitled to a pre-retirement death benefit. There are no death benefits payable from the Basic Plan for survivors of a non-vested participant.

If a participant has at least 120 Credited Service Months at the time of death and has not previously retired under the Basic Plan, the participant's spouse* will receive monthly benefits for life commencing in the month following the death of the participant. The spouse* of a participant who is vested with fewer than 120 Credited Service Months is also entitled to survivor benefits, but those benefits are deferred until the first of the month following the date the participant would have turned age 65.

For non-married participants (including those married for less than 12 months) with at least 120 Credited Service Months, monthly benefits are payable to the designated beneficiary(ies) payable upon the participant's death. Those monthly benefits are payable for ten years. No death benefits are payable from the Basic plan for non-married vested participants with fewer than 120 Credited Service Months.

The amount payable depends upon the participant's total Credited Service Months, Career Average Salary, and age at death. Please refer to your Pension Booklet for a more detailed explanation of the benefits.

* For these purposes, the participant and the legal spouse must have been married for the 12-month period immediately preceding death.

The Supplemental Pension Plan Death Benefit

The death benefit payable from the Supplemental Plan is the participant's Individual Account Balance. If the participant is married at the time of death, the Individual Account Balance will be converted into a lifetime benefit for the participant's spouse, unless she/he elects otherwise. If the participant is not married at the time of death, benefits are payable as a lump sum to the designated beneficiary(ies).

For a full explanation of benefits, please refer to your Plan Booklet. Feel free to call the Plan Office if you have any questions.

INSTRUCTIONS FOR BENEFICIARY DESIGNATION FORM

PLEASE NOTE: Incomplete forms will be returned.

- 1 NAME:** Print your complete legal name, last name first
- 2** Enter your **SOCIAL SECURITY NUMBER**. If you do not have a United States Social Security Number, please write "Foreign" in the space provided.
- 3 MARITAL STATUS:** Check all boxes that apply. Please provide date of marriage, divorce or spouse's death, if applicable.
- 4** Check the applicable box to indicate if you are currently receiving a monthly check from the Pension Plans
- 5 PRIMARY BENEFICIARY(IES):**

Name and address: Print the name(s) of beneficiary(ies), last name first. If beneficiary is a trust, estate or organization, also provide name and telephone number of contact person.
Social Security Number: REQUIRED. If no United States Social Security Number, please write "Foreign" in the space provided.
Relationship: List the beneficiary's relationship to you (Husband, Wife, Daughter, Son, Mother, Father, Friend, etc.)
Birth Date: REQUIRED. Enter the beneficiary's birth date (month, day, year)
Plan: For each beneficiary listed, enter one of the following:

 - ALL Beneficiary to receive all benefits (Basic and Supplemental Pension Plan death benefit)
 - B Beneficiary to receive Basic Pension Plan death benefit
 - S Beneficiary to receive Supplemental Pension Plan death benefit

If no plan is designated it will be presumed that all plans are to have the same beneficiary

% of Benefit: If listing more than one Primary Beneficiary or more than one Secondary Beneficiary, indicate the percentage each should receive. These percentages must add to 100% in each of the Primary Beneficiary section and the Secondary Beneficiary section. Enter "equal" if all beneficiaries are to receive equal shares.

If you wish to name more beneficiaries than there is room for on the form, please attach, sign and date an additional page.
- 6 SECONDARY BENEFICIARY(IES):** The Secondary Beneficiaries will be paid in the event that none of the Primary Beneficiaries survive the participant. In addition, the Secondary Beneficiaries will receive the remainder of benefits due should all of the Primary Beneficiaries die prior to the payment of all benefits. Complete this section in the same manner as the Primary Beneficiaries.
- 7 PARTICIPANT SIGNATURE:** Sign and date. This must be the signature of the participant. It cannot be signed by a spouse, attorney, business manager or anyone else other than the participant.
- 8 SPOUSAL CONSENT:** This section must be completed and notarized if the Primary Beneficiary is other than the participant's legal spouse.
- 9** Return the form with original signatures to the Plan Office. Be sure to make a copy for your records.

If you wish to change your beneficiary designation in the future, call or write the Plan Office for a new designation form. This form is also available at www.dga.org in the FORMS section of PENSION AND HEALTH





Beneficiary Designation Form -- For Pension Death Benefits

Instructions For This Form Are On The Reverse

Participant Name (Last, First, MI)				Social Security #: -- --	
Marital Status – Check as many as apply	<input type="checkbox"/> Single	<input type="checkbox"/> Married Date: _____	<input type="checkbox"/> Divorced Date: _____	<input type="checkbox"/> Widowed Date: _____	
Are you currently receiving a pension from the DGA-Producer Pension Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Please Print

PRIMARY BENEFICIARY(IES) IN EQUAL SHARES OR AS DESIGNATED BELOW					
NAME (Last, First, MI) and Address	Social Security #	Relationship	Birth Date	Plan	% of Benefit

SECONDARY BENEFICIARY(IES) IN EQUAL SHARES OR AS DESIGNATED BELOW					
NAME (Last, First, MI) and Address	Social Security #	Relationship	Birth Date	Plan	% of Benefit

I appoint the above as beneficiaries under the Directors Guild of America - Producer Pension Plans. I understand that completion of this form revokes any prior beneficiary designations I may have made.

 (Participant's signature)

 (Date)

 (Telephone number)

Spousal Consent -- REQUIRED IF LEGAL SPOUSE IS NOT THE SOLE PRIMARY BENEFICIARY MUST BE NOTARIZED	
I, _____, am the spouse of _____, (Name of Spouse) (Name of Participant)	
and hereby consent to the appointment of the above-mentioned person(s) or entity(ies) as primary beneficiary(ies) of death benefits payable under the Directors Guild of America - Producer Pension Plans.	
_____ (Spouse's Signature)	
State of _____, County of _____. On _____ before me,	
_____, personally appeared _____ (Name, Title of Officer -- e.g., "Jane Doe, Notary Public") (Name of Signer)	
<input type="checkbox"/> Personally known to me -OR- <input type="checkbox"/> Proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her/their authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.	
WITNESS my hand and official seal _____	