

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 and Payment 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 (required semi-annually or annually). One dependent premium (currently \$720 annually) covers all of your dependents. The dependent premium can be paid in six-month increments (*i.e.* \$360), but not for a lesser period of time. Payment may be made by check, credit card or bank account debit. If you would like to pay by check, please make the check payable to **DGA-PRODUCER HEALTH PLAN**. If you would like to pay the dependent premium by credit card or bank account debit, please fill out the applicable section of the **Dependent Enrollment and 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 18 and your spouse's natural unmarried children up to age 18	Certified birth certificate
Your adopted unmarried children up to age 18 or unmarried children up to age 18 dependent upon you for support that are living with you in a normal parent-child relationship.	Adoption or Guardianship documentation
Your unmarried children age 19-22, provided they are attending an accredited school on a full-time basis	A student verification form must be completed by the accredited school. This verification form must be submitted semi-annually for the following two eligibility periods: <ul style="list-style-type: none"> • October 1 to January 31; and • February 1 to September 30. The student verification form must indicate that the student is enrolled full-time and give the start and end dates of the term.
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.

DEPENDENT ENROLLMENT AND PAYMENT FORM

If you are adding or dropping dependents from coverage or would like to pay your dependent 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: _____

Participant Signature: _____

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

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

One dependent premium covers all of your dependents. If you would like to pay the premium by credit card or bank account debit, fill out the section below. The premium can be paid in six-month increments, but not for a shorter period.

Paying by Credit Card
Amount to Charge: <input type="checkbox"/> \$360 <input type="checkbox"/> \$720
Charge Frequency: <input type="checkbox"/> One-Time <input type="checkbox"/> Recurring
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
Amount to Charge: <input type="checkbox"/> \$360 <input type="checkbox"/> \$720
Debit Frequency: <input type="checkbox"/> One-Time <input type="checkbox"/> Recurring
<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 every six months while my dependents are covered under my Health Plan coverage. 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: _____ Date: _____