

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: _____