PENSION DEDUCTION AUTHORIZATION FORM

If you would like to pay your premium directly from your Basic Plan monthly pension benefit each month, please return this form to the Health Plan office **via the myPHP online benefits portal** (To register, have your Plan ID number ready and visit dgaplans.org/myPHP.), mail to **DGA–Producer Health Plan, 5055 Wilshire Blvd, Suite 600, Los Angeles, CA 90036**, email to **Eligibility@dgaplans.org**, or fax to **(323) 866-2399**.

Your completed form must be received by the 15th of the month in order to begin pension deduction the following month.

Participant Name: ______________________________

Health Plan ID Number: ______________________________

Daytime Phone Number: ______________________________

I hereby authorize the DGA-Producer Pension Plan to deduct from my Basic Pension Plan monthly benefit and remit to the DGA-Producer Health Plan an amount equal to my monthly self-pay health premium. The DGA-Producer Health Plan has no enforceable right in, or to, any plan benefit payment or portion thereof, except to the extent of payments actually received during the terms of this agreement.

I understand that if there is a stoppage or reduction to my monthly Pension Plan benefit due to suspension, death or any other reason, I and/or my dependents are responsible for the premiums due to the Health Plan or my coverage will be canceled. I understand that this election is revocable by me at any time and that the DGA-Producer Health Plan reserves the right to cancel this agreement at any time by notifying me in writing.

Participant Signature: X ______________________________

Date: ______________________________

ADMINISTRATIVE USE ONLY

Deduction Effective Date: ______________________________

Monthly Premium Amount: ______________________________