Writers’ Guild Industry-Health Fund
Coordination of Benefits Form

Please submit this form with all supporting documentation to The Fund

Mailing Address: 2900 West Alameda Ave., Suite 1100, Burbank, CA 91505 or access this form on our website at:
www.wgaplans.org

SUBSCRIBER INFORMATION  (Please Print Clearly or Type)

<table>
<thead>
<tr>
<th>Participant’s Name: ____________________________</th>
<th>Participant ID #: WRXA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse’s Name: __________________________________</td>
<td>Spouse’s Date of Birth: __________</td>
</tr>
<tr>
<td>Spouse’s Employer Address/Phone Number: ____________________</td>
<td></td>
</tr>
</tbody>
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COVERAGE INFORMATION

Please note: If you, your spouse or dependent(s) have: (check applicable box)

- [ ] No other group health insurance coverage, then sign and date the form in Part D
- [ ] Other coverage, please complete Part A1, then sign and date the form in Part D
- [ ] Been Divorced/legally separated, please complete Part A and Part B, then sign and date the form in Part D
- [ ] Medicare coverage, please complete Part C, then sign and date the form in Part D

Part A

If you, your spouse or dependent(s) have other coverage, list each separately

<table>
<thead>
<tr>
<th>Carrier Name: ____________________________</th>
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<tbody>
<tr>
<td>Carrier Address: ____________________________</td>
</tr>
<tr>
<td>Subscriber’s Name: ____________________________</td>
</tr>
<tr>
<td>Policy Effective Dates: Start: _______ End: _______ Covered Dependents: ____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Type:</th>
<th>Type of Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Retiree</td>
</tr>
<tr>
<td>Mental Health</td>
<td>COBRA</td>
</tr>
<tr>
<td>Prescription</td>
<td>Individual</td>
</tr>
<tr>
<td>Dental</td>
<td>Self Pay</td>
</tr>
<tr>
<td></td>
<td>Active</td>
</tr>
</tbody>
</table>

If previous coverage terminated within the last two years, you must enclose documentation from the former carrier indicating the date the policy was terminated.
Please complete this section if you are divorced or legally separated, and you have dependent children covered under this plan.

1. Does the other custodial parent of your dependent children provide health benefits?  
   □ Yes  □ No

   Name of other custodial parent: ____________________________  Birth date: ____________

   If yes, please provide the following information:

   Name of other health plan: ________________________________

   Policy/Group #: ____________________________

   Subscriber ID #: ________________________________

   Which children are covered?

2. If divorced, check one of the following:  
   Date of divorce/separation: ____________

   □ Divorce decree stipulates other parent must provide health benefits
   □ Divorce decree stipulates joint custody
   □ Divorce decree does not stipulate any special provisions
   □ Other, please explain: ________________________________

   * A copy of the section of the court decree pertaining to health coverage or other documents must be provided to support your response.

   *** IMPORTANT NOTE: If you are over age 65, you must enroll in Medicare part A & B ***

You should complete this section if you, your spouse, and/or your dependents are eligible for Medicare. Please enclose a copy of the Medicare ID card for each eligible member of your family.

Name of Participant eligible for Medicare: ____________________________

Name of Dependent eligible for Medicare: ____________________________

Effective Dates of Medicare:
Part A: ____________________________  Part B: ____________________________

Effective Dates of Medicare:
Part A: ____________________________  Part B: ____________________________

If you are under age 65 are you enrolled in Medicare due to a disability?  
   □ Yes  □ No

PARTICIPANT SIGNATURE

__________________________________________  Signature and date is required

I certify that the above information is correct and understand that I am obligated to provide this information to the Writers’ Guild Health Fund with the Certificate of Coverage. If other coverage is added or terminated for any individuals covered under my Writers’ Guild-Industry Health Fund Plan, I must notify the Fund immediately. Failure to provide complete and accurate information may result in a delay in the payment of benefits and/or can result in the incorrect handling of your claim.

Print Your Name: ____________________________________________

Signature: ____________________________________________  Date: ____________

Participant ID Number: WRXA

WRITERS’ GUILD-INDUSTRY HEALTH FUND
2900 W. Alameda Ave
Suite 1100
Burbank, CA 91505
ATTN: CLAIMS DEPARTMENT
Phone Number: (818) 846-1015 or (800) 227-7863