

DEPENDENT ENROLLMENT FORM

In order to add or reinstate your spouse, or dependent children to your insurance policy, please submit the following documentation when returning this completed form. Please circle the appropriate relationship code below. Please use the back of this sheet if necessary.

You MUST prepay a quarterly dependent premium of \$150.00 (\$600 per year) to cover all of your dependents. Please make check payable to the Writers' Guild-Industry Health Fund.

SPOUSE

A copy of the certified marriage certificate.

CHILD:

A copy of the certified birth certificate.

ADOPTION, FOSTER CARE, GUARDIANSHIP:

A copy of the adoption/release or guardianship placement documents.

Name of Participant _____	Address _____	Participant ID. # _____	DOB _____	Sex _____
E-Mail Address _____		Phone Number _____		

PLEASE LIST EACH DEPENDENT'S LEGAL NAME

First Name MI Last Name _____	SP CH SC AC KC _____	Soc. Sec. # _____	DOB _____	Sex _____
First Name MI Last Name _____	SP CH SC AC KC _____	Soc. Sec. # _____	DOB _____	Sex _____
First Name MI Last Name _____	SP CH SC AC KC _____	Soc. Sec. # _____	DOB _____	Sex _____
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First Name MI Last Name _____	SP CH SC AC KC _____	Soc. Sec. # _____	DOB _____	Sex _____

Dependent Codes: **SP** (Spouse) **CH** (Child) **SC** (Step Child) **AC** (Adopted Child) **KC** (Legal Ward Child)