STAFF COVERAGE FORM

Thank you for choosing the PHBP. Please fill out and sign this form and return it with your signed Participation Agreement. All documents can be found at www.phbp.org

Participating Company is primarily:

☐ Live Action Production ☐ Digital Production ☐ Post Production ☐ Associate Member

☐ **I decline Staff coverage and will participating in Freelance Production contributions only.**

☐ **I elect Staff coverage.**

Section I: Election of Staff Coverage Benefit Offerings:

The PHBP offers two Staff Coverage Packages.

Please check and initial one of the following staff coverage options. All terms and conditions apply as per the Participation Agreement :

		Check:	Initial:
Option 1:	Medical and Pharmaceutical Benefits Only	_____	_____
Option 2:	Medical/Pharmaceutical AND Vision/Dental	_____	_____

Monthly Premium Amounts

*Your specific employer provided medical coverage plans will be selected on your staff employees' enrollment forms.

Option 1- Medical and RX Only:

	PHBP Classic Premier PPO	**PHBP Classic Plus PPO**	**PHBP Health Savings Account (HSA)**	**PHBP California Classic HMO (CA Only)**
Employee Only	$ 612.13	$. 576.35	$ 408.19	$. 441.26
Employee + Spouse	$1,359.63	$1,280.20	$ 906.67	$. 980.12
Employee + Children	$1,112.42	$1,047.44	$ 741.83	$. 801.92
Employee + Family	$1,912.93	$1,801.18	$1,275.65	$1,378.98

Option 2- Medical PLUS the following Dental and Vision bundle:

** If elected, this bundle must be provided to all covered staff employees. It cannot be purchased individually per employee.

Employee Only	$ 44.36
Employee + Spouse	$ 85.52
Employee + Child	$. 93.86
Employee + Family	$132.83

PHBP will be offering a short and long term disability package that will be available on April 1, 2019. If you are interested, we will need employee income data by February 1, 2019.

☐ Check here if interested and more information will be provided in January 2019.

Date Agreed, Accepted, and Signed: _____

Full Name of Contributing Employer: _____

Address of Contributing Employer: _____

Authorized Signature: _____

Printed Full Name: _____

Staff Coverage Point of Contact: _____

Phone Number: _____

Email Address: _____

The above signed Contributing Employer agrees to cover all staff employees for individual coverage, and to pay in full each month all individual staff and dependent contribution rates directly to the PHBP via its online secure payment portal or by check. Upon receipt of this signed Election Form, BeneSys Administrators will provide you with all needed Staff Enrollment forms. All forms are also available at www.PHBP.org

No coverage will be provided to, nor payment due for, staff employees who decline coverage in writing as prescribed by PHBP.

The purpose of this form is to elect staff coverage along with any additional benefits. All other details are informational only. Your signed Participation Agreement shall govern all Plan policies and details. If you have any questions, please call Sean Cooley, Executive Director of PHBP, at 323-960-4781 or inquire by email to seanc@phbp.org.