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 explanations of Benefits can be found at phbp.org/documents.

Participating Company is primarily:

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

☐ **I DECLINE staff coverage and will participate in Freelance Production contributions only.** I acknowledge that a working owner cannot also be a freelance employee of the company and no working owner of this company, including myself, will receive Freelance contributions under this agreement.

☐ **I ELECT Staff coverage. Current number of eligible Staff employees to be covered: _____.**

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:

Note: The cost-sharing ceiling that you may elect your employees to contribute is 50% of the cost of coverage. The cost sharing of dependent coverage is at the employer's discretion.

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

Each employee's selected medical plan must be indicated on the Enrollment forms and cannot be changed after the effective date of coverage except during open enrollment in December.

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 not can it be added at a later date except during open enrollment in December for coverage effective January 1.

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

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.

OFFICE USE ONLY:

Countersign Date: _____, 2019

Coverage to start 1st of _____, 2019

Special Enrollment (Y/N): _____

Type of Proof Provided: _____