SAG-AFTRA HEALTH PLAN SAG-PRODUCERS PENSION PLAN

3601 W. Olive Ave., Burbank, CA 91505 • Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830 P (800) 777-4013 • F (818) 953-9880 • www.sagaftraplans.org

Participant Information Form

Please update us every time you change your address, phone number and/or email. This information is shared between the SAG-AFTRA Health Plan and the SAG-Producers Pension Plan if you are a participant of both Plans. For more information about eligibility requirements with these Plans, please visit www.sagaftraplans.org.

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Legal name* (first, middle, last):										
Date of birth (MM/DD/YYYY): / /	DD/YYYY): Gender: / □Male □Female		Social Secu	rity number: 						
Address 1:										
Address 2:										
City:	State:	Zip:		Country:						
Email:			Alternate email:							
Home phone:		Mobile phone:								
This is a confidential legal document and must be signed by the participant before it can be accepted as a valid record. If the participant is a minor, the parent or legal guardian must sign this document.										
Signature				Date						
Relation to participant (if participant is	a minor)									

^{*}We require your full legal name to administer your benefits.