SAG·AFTRA
HEALTH 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/health

Employer Request for Staff Coverage

A "staff participant" is a full-time employee of a radio or television station or network that contributes to the SAG-AFTRA Health Plan under a collective bargaining agreement. A staff participant qualifies to enroll in the Plan on the first day of the month after 30 days of full-time employment with a contributing employer. A staff participant's salary will determine their qualification for Plan I or Plan II coverage based on the minimum earnings requirement. The Plans' minimum earnings requirement is available at www.sagaftraplans.org/health/eligibility.

How a staff participant enrolls in the Plan

- A contributing employer's representative completes the Employer Request for Staff Coverage Form (see back of this document) within 30 days of full-time employment.
- The participant completes and submits a Participant Information Form – available at www.sagaftraplans.org/health or by calling (800) 777-4013. If enrolling dependents, the participant must also include acceptable documentation (recorded marriage or birth certificate, etc.).
- The participant must pay premiums in full and on time.

Send the completed forms and documentation to the Plan at the mailing address at the top of this page. The information can also be emailed to stationstaff@sagaftraplans.org or faxed to (818) 973-4465. To save time, please send the completed Participant Information Form when you send the Employer Request for Staff Coverage Form.

After the Plan receives your forms and documentation, you will receive an invoice for the premium due. You will then have 30 days from the date of the invoice to make the premium payment. Premiums can be paid by mail, online in your Benefits Manager at www.sagaftraplans.org/health, or by signing up for automatic premium payments.

When employment ends

Staff participants continue to qualify for Plan coverage as long as they maintain full-time employee status. If an employee discontinues full-time work as a staff participant before being enrolled in the Plan for five consecutive years, qualification for Plan coverage will end on the last day of the calendar quarter following the quarter in which full-time employment ended. If the participant is enrolled continuously in the Plan for five or more consecutive years when full-time employment ends, coverage will end on the last day of the last qualified coverage period. The participant and any covered dependents whose coverage ends will then be offered the opportunity to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), provided the Plan receives that participant's COBRA application within 60 days from the date active coverage ended.

COBRA requires employers to notify a group health plan within 30 days of an employee's employment termination or reduction in hours. The Plan depends on radio/television stations or networks to notify it within this 30 day period so the Plan can inform staff performers of their rights to COBRA continuation coverage when they lose active Plan coverage due to their change of employment status.

Employer Request for Staff Coverage Form

Please read the instructions on the reverse side before providing the information requested below.

Employer information
Employer name:
Station call letters:
Station address (street):
Station address (city, state, zip):

Employer representative	
Name:	Title:
Phone:	Email:

Employee information		
Employee name (first, middle, last):		
Date of birth (MM/DD/YYYY): / /	Gender: ☐ Male ☐ Female	Social Security number: — —
Employee's annual salary (as of signature date below):	Employee's position title:	Date covered position began: / /
Employee is: ☐ New hire ☐ Part-time to full-time employment ☐ Change from non-union to union position ☐ Transferring from corporate plan during open enrollment ☐ Other _____		
Premium payroll deduction: ☐ Yes ☐ No If Yes, start date: / /		
Employee mailing address (street):		
Employee mailing address (city, state, zip):		
Phone:	Email:	

I certify that all the information provided on this form and on any attached documents is accurate and complete. I understand that the contributing employer must notify the SAG-AFTRA Health Plan within 30 days if the participant's status as a full-time employee changes.

_____ _____ / /

Employer signature Date

Email to: stationstaff@sagaftraplans.org

Office use only
Coverage start: _____
☐ Plan I ☐ Plan II