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.

Please tell us about you

Legal name* (first, middle, last):			
Date of birth (MM/DD/YYYY): / /	Gender: ☐Male ☐Female	Social Security 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.*