|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PARTICIPANT:** | {stdMbrFullNameInProperCase} | | | | **BIRTH DATE:** | | {stdMbrDateOfBirth} | |
| **SPOUSE:** | {stdMbrSpouseFullName} | | | | **BIRTH DATE:** | | {stdSpouseDateOfBirth} | |
| **RETIREMENT DATE:** | | {dtRetirementdt} | **TYPE:** | Health Only | **YEARS:** | {yrs} | **HOURS:** | {hours} |

To the Board of Directors of the Motion Picture Industry Pension Plan (“Pension Plan”), Motion Picture Industry Account Plan (“IAP”), and the Motion Picture Industry Retiree Health Plan (“Retiree Health Plan”) (collectively “the Plans”):

This is to notify you that I, **{stdMbrFullNameInProperCase}**, intend to retire from the motion picture industry (the “Industry”) and start my benefits from the Retiree Health Plan on **{strRetirementDate}**.

**PLEASE READ CAREFULLY BEFORE SIGNING**

**I understand that:**

1. I am voluntarily electing to start my health benefits under the Retiree Health Plan. The plan does not require me to start my benefits.
2. Except as provided below, I will receive retiree health benefits starting on my Retirement Date. I understand my health benefits will continue as long as I live, provided I remain in retirement from the Industry.
3. I will be considered a Retired Employee when I do not work in (or receive any consideration from) the Industry (whether or not my employer contributes to the Plans) for two complete calendar months immediately following my Retirement Date.
4. I am only applying for Retiree Health Plan benefits. I am not retiring from the Pension Plan and the IAP at this time. I also understand that I must complete a separate Retirement Application at least two complete calendar months prior to commencing my Pension Plan and IAP benefits.
5. When I, my spouse, or any eligible and enrolled dependents become entitled to Medicare benefits due to reaching age 65 or upon disability, the individual who is Medicare entitled must enroll through the Social Security Administration for Medicare Part A and Part B benefits.
6. At age 65 or upon disability, Medicare will become the primary payer for health benefits. The Retiree Health Plan will not pay for benefits I or my eligible dependents would otherwise be entitled to receive by another health plan, including Medicare.
7. Dependents age 19 and older who are not full time students are not eligible for coverage under the Retiree Health Plan. Dependents with coverage under the Active Health Plan who lose coverage because of my transfer to the Retiree Health Plan are eligible for continuation coverage under COBRA.

**PARTICIPANT’S CONSENT**

I understand that this application must be received by the Plans at least two complete calendar months prior to the retirement date indicated above, or it will not be accepted. If I want to cancel this application after returning it to the Plans by the initial deadline, the Plans must receive a completed, signed **Cancellation Form** prior to my Retirement Date.

Under penalty of perjury, I certify that my current marital status is: Single Married Divorced

My signature on this document indicates that I have read and understand the terms and conditions of this application.

Participant’s Signature Date

*i.e.,* no later than **{dtSixtyDaysPrior},**