HEALTH BENEFITS ENROLLMENT FORM

Employee Information

Last Name , First Name		Social Security Number	Plan Options
Address (street, city, state, zip)		Date of Birth	Medical Plan (check one only) AETNA HMO ☐ (IN CA ONLY) AETNA POS ☐ AETNA BASIC PPO ☐
Cell Phone	Office Phone	Personal Email	Dental Plan (check one only) AETNA DMO® ☐ AETNA PPO ☐ Vision Service Plan ☐

List YOUR name and eligible dependents below (check MEDICAL/DENTAL/VISION boxes for coverage)
Marriage certificate required to add spouse and birth certificate(s) required to add children (unless previously provided)

Last Name , First Name	SSN	DOB	Sex M/F	Relation to Employee	MEDICAL	For HMO only CA only Doctor #[1]	Current Y/N	DENTAL	For HMO only Dentist #[1]	Current Y/N	VISION
				SELF	☐			☐			☐
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RETURN THIS FORM WITHIN 30 DAYS OF YOUR ELIGIBILITY DATE TO: BENEFITS, 3500 W. OLIVE AVENUE #1000, BURBANK, CA 91505, FAX (818) 972-8992
OR SCAN TO CATHY.MARCUS@WARNERBROS.COM PHONE (818) 972-8914 OR (818) 972-0787

EMPLOYEE AUTHORIZATION (Required)

I hereby authorize the transactions indicated on this form, including payroll deductions, if any, on a pre-tax basis for the coverage I elect. I further state that I understand that the election(s) I make cannot be changed until the next Open Enrollment period or within 30 days of a qualified change in status or other circumstances as defined by the Internal Revenue Code. I further state that all information furnished is true and complete to the best of my knowledge and I authorize the carrier or agent to obtain medical records and information from providers relating to me and my eligible dependents, to the extent required to provide administrative services in connection with the plans.

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Employee Signature **Date**

Date of Hire	Eligibility Date	Production

For office use only

[1] Use DocFind at www.aetna.com to find Primary Medical/Dental Office IDs