PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Employer Group Waiver Plan (EGWP) Opt-Out Election Form

Writers' Guild-Industry Health Fund

EFFECTIVE DATE OF ENROLLMENT: January 1, 2027

The Writers' Guild-Industry Health Fund (the "Fund") automatically enrolls eligible Certified Retirees, along with their eligible Medicare-eligible dependents, in an Employer Group Waiver Plan (EGWP) for prescription drug coverage. Each Medicare-eligible individual is enrolled separately, so a Certified Retiree and a Medicare-eligible dependent must each make their own opt-out election. If you and/or your dependent do not wish to participate in the EGWP, you may each opt out by completing this form. Please read the information below carefully before making your election.

Warning: If you opt out of the EGWP, you will lose your Fund-sponsored prescription drug coverage and will not be able to re-enroll until the next annual enrollment period, unless you experience a qualifying event. Please contact the Fund office with any questions before submitting this form. Prior to opting out, you are strongly encouraged to set up a counseling appointment with the Fund Office to discuss your decision.

CONSENT TO RELEASE AND DISCLOSURE OF INFORMATION
By joining this Medicare prescription drug plan, you acknowledge that the Fund will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that the Fund will release your information, including your prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

Participant Information

Participant Name

Full legal name

Member ID Number

As shown on your Fund ID card

Date of Birth

MM / DD / YYYY

Medicare Number (as shown on your Medicare card)

Mailing Address

Street, City, State, ZIP

Daytime Phone Number

Dependent Information

Complete this section only if a Medicare-eligible dependent is also opting out of the EGWP. Each Medicare-eligible dependent must make their own election; please complete a separate form for each additional dependent.

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Dependent Name

Full legal name

Relationship to Participant

Date of Birth

MM / DD / YYYY

Medicare Number (as shown on dependent's Medicare card)

Election

☐ PARTICIPANT: I elect to OPT OUT of the Employer Group Waiver Plan (EGWP) prescription drug coverage offered by the Writers' Guild-Industry Health Fund. I understand the consequences described above, including that I will lose EGWP prescription drug coverage and may not be able to re-enroll until the next annual enrollment period or a qualifying event.

☐ DEPENDENT: I elect to OPT OUT the dependent named above from the Employer Group Waiver Plan (EGWP) prescription drug coverage offered by the Writers' Guild-Industry Health Fund. I understand the consequences described above, including that the dependent will lose EGWP prescription drug coverage and may not be able to re-enroll until the next annual enrollment period or a qualifying event.

Signature

By signing below, I certify that the information provided on this form is true and accurate, and that I am the participant, the dependent, or the authorized representative of the participant or dependent named above.

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this Opt-Out form means that I have read and understood the contents of this form. If signed by an authorized representative (as described above), this signature certifies that: 1) this person is authorized under State law to complete this election, and 2) documentation of this authority is available upon request by the Fund or Medicare.

Print Name

Participant / Authorized Representative — please print*

Signature | Date

Participant / Authorized Representative Signature | *MM / DD / YYYY*

Relationship to Participant (if signing on participant's or dependent's behalf)

If a dependent is opting out, the dependent or the dependent's authorized representative should also sign below.

Dependent Print Name (if applicable)

Dependent / Authorized Representative — please print*

Dependent Signature (if applicable) | Date

Dependent / Authorized Representative Signature | *MM / DD / YYYY*

**Proper documentation establishing the authority of the authorized representative, such as a guardianship or power of attorney, must be on file with the Fund Office.*

Please return this completed form to the Writers' Guild-Industry Health Fund office by mail or secure upload.2900 W Alameda Ave #1100, Burbank, CA 91505, and/or the participant portal link at wgaplans.org.

For information about the EGWP and Certified Retiree coverage, visit wgaplans.org or call Monday – Friday, 8:30 AM to 5:00 PM PT. General: (818) 846-1015 or (800) 227-7863.

For questions about your Medicare benefits, call 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048, 24 hours a day, 7 days a week, or visit www.medicare.gov. The call and the help are free.