HEALTH AND DENTAL PLANS ADMINISTRATION
111 North Hope Street Room 564
Los Angeles CA 90012
Tel: (213) 367-2023 Fax: (213) 367-2078
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ENROLLMENT/CHANGE FORM

ACTIVE EMPLOYEE

EFFECTIVE DATE

1 TRANSACTION TYPE

- ☐ NEW ENROLLMENT
- ☐ ADDITION/DELETION OF DEPENDENT
- ☐ CANCELLATION OF ENROLLMENT
- ☐ DECLINE/TERMINATE COVERAGE
- ☐ OTHER ____________________

If you wish to enroll, change, or cancel an IBEW Local 18 sponsored plan you must contact IBEW Benefit Service Center at (800) 842 6635.

2A HEALTH PLANS

- ☐ Kaiser Permanente
- ☐ Health Plan of Nevada
- ☐ United Healthcare HMO
- ☐ United Healthcare PPO
- ☐ United Healthcare Non-Differential/Owens Valley

2B DENTAL PLANS

- ☐ Delta Dental PPO
- ☐ United Concordia HMO

3 EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security No.	Employee No. (REQUIRED)

Date Hired	Home Address	City	State	ZIP Code

Daytime Phone No.	Birth Date	Sex	Previous Name
		☐ M ☐ F	

4 DEPENDENTS TO BE ENROLLED

Last Name	First Name & MI	Birth Date	Social Security No.	Sex	Relationship	DWP Employee (Yes or No)

If enrolling a spouse please provide a copy of Marriage Certificate. If enrolling a Domestic Partner, provide copies of Drivers Licenses or ID showing same address and an Affidavit of Domestic Partnership

Date of Marriage or Start of Domestic Partnership: ____________________

Please note a Social Security Number is required to verify eligibility of your dependents.

5 DEPENDENTS TO BE DELETED

Last Name	First Name & MI	Birth Date	SSN (Last 4 Digits)	Relationship	Reason for Deletion

Date of Divorce: ____________________ Date of Death: ____________________

Must provide a copy of final divorce decree

I hereby authorize DWP to deduct from my earnings, from time to time until further notice, amounts equal to the contributions required of me towards the plan(s) herein enrolled. I understand that if I decline coverage, I will not be able to enroll for health or dental coverage until the next Open Enrollment period, unless I have a change in status.
I understand that all of my benefit choices shown here will be in effect until the next Open Enrollment unless I have a qualifying event. I understand that any dispute or controversy that may arise under the agreement between me and/or any family member and any Health Maintenance Organization named above, or any participating office, must be submitted to binding arbitration in lieu of a jury or court trial.

Employee Signature:	Date:

PLEASE READ INSTRUCTIONS AND IMPORTANT INFORMATION AT THE BACK

Important Information

When to Enroll:

- New employees, transfers from another City of Los Angeles Department, or changes of employment status must enroll within 31 days from Hire Date with LADWP or change in employment status
- Enroll dependents within 31 days from the qualifying event such as marriage, completion of the prescriptive period of domestic partnership, birth of a child/grandchild, and adoption or custody of a child

Effective Date of Coverage:

- The coverage is effective on the first of the month following receipt of enrollment forms and eligibility documents, if any, in the Health and Dental Plans Administration Office
- The effective coverage date for changes made during the Open Enrollment period is July 1st

Who can be your Eligible Dependents:

If you are enrolling:	***You must submit a copy of the . . .***
Your lawful spouse	Certified marriage certificate
Registered domestic partner	Declaration of Domestic Partnership issued by the California Secretary of State or an equivalent document issued by another state or any local agency in California or another state
Nonregistered domestic partner	Copies of you and your domestic partner's California driver's licenses or identification cards and that it matches your address of record with LADWP **AND** a completed Affidavit of Domestic Partnership
Biological and stepchild(ren)	Birth certificate of the child
Child(ren) of domestic partner	Birth certificate of the child (Domestic partner of child(ren) must be enrolled in coverage)
Adopted child	Birth certificate of the child and adoption documents
Children under your Legal Guardianship	Birth certificate of the child and Court Order appointing you or your spouse as legal guardian of the child
Grandchild(ren)	Birth Certificate of the child (Parent of grandchild(ren) must be enrolled in coverage)

Refer to the Benefit Guide for all eligible dependents and full list of required and acceptable documents to verify eligibility.

COBRA Information

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides group health insurance continuation to employees, spouses, and dependent children if they lose group health insurance due to certain qualifying events. Two qualifying events under COBRA require you, your spouse, or dependent child to follow certain notification rules.

You are required to notify the LADWP Health and Dental Plans Administration Office of a divorce/legal separation or if a child ceases to be a dependent child under the terms of the LADWP's Group Health or Dental Insurance plan.

Each covered employee or spouse or dependent child is responsible for notifying the Plan Administrator within 60 days after the date of divorce or the date the dependent child ceased to be a dependent as defined under the LADWP Health and/or Dental Insurance plan.

Failure to properly notify the LADWP Health and Dental Plan Administration Office within the required 60 days will forfeit all COBRA rights that may have arisen from these two qualifying events.

Please read you Options Guide for the definitions of spouse and dependent children.

Contact the LADWP Health and Dental Plans Administration Office at (213) 367-2023 for proper procedures and forms to be used to make this required COBRA notification

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