DEPARTMENT OF WATER AND POWER
HEALTH AND DENTAL PLANS ADMINISTRATION
111 North Hope Street Room 564
Los Angeles CA 90012
Tel: (213) 367-2023 Fax: (213) 367-2078

# ENROLLMENT/CHANGE FORM

## ACTIVE EMPLOYEE

**EFFECTIVE DATE**

## 1 TRANSACTION TYPE

- ☐ NEW ENROLLMENT
- ☐ ADDITION/DELETION OF DEPENDENT
- ☐ CANCELLATION OF ENROLLMENT
- ☐ 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 (Owens Valley)

## 2B DENTAL PLANS

- ☐ Delta Dental PPO
- ☐ United Concordia HMO

## 3 EMPLOYEE INFORMATION

| Last Name | First Name | MI | Social Security No. | Employee No. |
|---|---|---|---|---|
| | | | | |

| 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 | Provider No. |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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| | | | | | | |

*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 | Social Security No. | 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 there is a change in my status, my employment status or my spouses/domestic partner's employment status or loss of coverage. 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: |
|---|---|
| Spouse Signature: | Date: |

PLEASE READ INSTRUCTIONS AND IMPORTANT INFORMATION AT THE BACK