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. (Last 4 Digits)	Employee No. (REQUIRED)

Date Hired	Home Address	City	State	ZIP Code

Daytime Phone No.	Birth Date	Sex	Previous Name

4 DEPENDENTS TO BE ENROLLED

Last Name	First Name & MI	Birth Date	SSN (Last 4 Digits)	Sex	Relationship	Provider 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 (last 4 digits) 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 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