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

RETIREE

EFFECTIVE DATE

1 TRANSACTION TYPE

☐ NEW ENROLLMENT
☐ ADDITION/DELETION OF DEPENDENT
☐ ADDRESS CHANGE
☐ NAME CHANGE
☐ CANCELLATION OF ENROLLMENT

If you wish to enroll in, 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 / Senior Advantage
☐ United Healthcare HMO/Group Medicare Advantage
☐ Health Plan of Nevada
☐ UHC - HMO MA / Nevada
☐ United Healthcare PPO
Option: ________
☐ UHC PPO / Medicare Advantage
Option: ________

2B DENTAL PLANS

☐ United Concordia Preferred (PPO) ☐ United Concordia Plus (HMO)

3 SUBSCRIBER INFORMATION

Last Name	First Name	MI	Social Security No. (Last 4 Digits)	Employee No. (REQUIRED)

Home Address	City	State	ZIP Code	Email Address

Daytime Phone No.	Birth Date	Medicare Part A Effective Date	Medicare Part B Effective Date	Medicare Claim Number

4 DEPENDENTS TO BE ENROLLED

Last Name	First Name & MI	Birth Date	SSN (Last 4 Digits)	Sex	Relationship	Provider No.

If you are enrolling a spouse over age 65 or has Medicare, please provide information:	Medicare Part A Effective Date	Medicare Part B Effective Date	Medicare Claim Number

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.

IMPORTANT:	If you and/or your spouse/domestic partner or dependent child has Medicare, you will need to fill out additional forms such as: Senior Advantage Election Form or United Healthcare Medicare Rx Form; or Secure Horizons or Senior Dimension if you have Medicare A & B

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.

Retiree Signature:	Date:
Spouse Signature:	Date:

PLEASE READ INSTRUCTIONS AND IMPORTANT INFORMATION AT THE BACK

Important Information

Social Security No. (SSN):

- Please only enter the last four (4) digits of the Social Security No. (SSN) in the designated fields. DO NOT ENTER the full SSN in any of the fields.

When to Enroll:

- 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 in the Health and Dental Plans Administration Office

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
Biological children	Birth Certificate of the child
Stepchildren, children of Domestic Partner, grandchild	Birth Certificate of the child
Adopted child	Adoption documents
Children under your Legal Guardianship	Court Order appointing you or your spouse as Legal Guardian of the child

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