Southern California IBEW-NECA Health Plan
6023 Garfield Avenue
City of Commerce, California 90040
Mailing Address: P.O. Box 910918, Los Angeles, CA 90091
(323)221-5861 or (800) 824-6935 (Nationwide)

HEALTH AND DENTAL PLAN
OVER-AGE DEPENDENT
ONE-TIME
SPECIAL ENROLLMENT FORM
www.scibew-neca.org
Fax No. (323) 726-3520

PARTICIPANT INFORMATION		Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Last Name	First Name	MI
Street Address – **Do *NOT* use P.O. Box** / Apt. No.	City	
State / Zip Code / Phone	Birthdate	
Signature	Date	

ONE-TIME SPECIAL ENROLLMENT
ADDITION OF OVER-AGE DEPENDENT

The Patient Protection and Affordable Care Act ("PPACA") requires plans to extend coverage to adult children of covered participants until age 26. Please choose one of the following:

☐ Over-age dependent was previously dropped from the SC IBEW-NECA Health Plan.

☐ Over-age dependent is currently under 26 years of age, but has never been enrolled in the SC IBEW-NECA Health Plan.

☐ Children who are currently on COBRA continuation coverage because they lost eligibility under the plan.

This Special Enrollment runs until July 1, 2011. To enroll a currently ineligible dependent child, you must complete this form and return it with the required documentation to the Administrative Trust Funds Office postmarked not later than July 31, 2011. Coverage pursuant to this One-Time Special Enrollment shall be effective no earlier than July 1, 2011. **WARNING:** Failure to timely enroll jeopardizes any coverage under this Plan for the currently ineligible child.

A copy of a certificate of live birth or adoption papers must accompany this Special Enrollment Form.

Select a Health Plan: ☐ UnitedHealthcare (HMO) ☐ Anthem/Blue Cross Prudent Buyer (PPO) ☐ Kaiser Permanente (HMO)*Kaiser only – write in Family Account No. ___________________________

Select a Dental Plan: ☐ United Concordia DHMO ☐ United Concordia PPO ☐ DeltaCare DHMO ☐ CIGNA Dental DHMO ☐ MetLife/Safeguard Dental DHMO

ADD	DROP	Relationship (Check Box)	Last Name	First Name	MI	Date of Birth	Social Security Number	Primary Care Physician/Office No. Dental/Medical Group (if CIGNA, DELTACARE, United Concordia or Safeguard)
		☐ Son ☐ Daughter						
		☐ Son ☐ Daughter						
		☐ Son ☐ Daughter						
		☐ Son ☐ Daughter						
		☐ Son ☐ Daughter						

FOR OFFICE USE ONLY

Medical Group Number	Dental Group Number	Effective Date of Change: Month	Day	Year	Document received with Form:	Initials	Date
					☐ Adoption Papers ☐ Overage Certification	☐ Birth Certificate	