



Complete in blue or black ink.

PART 1: ACTION REQUESTED						
PARTICIPANT STATUS <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree	ADD <input type="checkbox"/> Coverage: Self <input type="checkbox"/> Coverage: Spouse <input type="checkbox"/> Coverage: Child(ren)	CHANGE <input type="checkbox"/> Transfer to Delta Dental DPPO <input type="checkbox"/> Transfer to Cigna DHMO (Prepaid Provider)	TERMINATE <input type="checkbox"/> Coverage: Self <input type="checkbox"/> Coverage: Spouse <input type="checkbox"/> Coverage: Child(ren)			
PART 2: APPLICANT INFORMATION						
LAST NAME		FIRST NAME		MI	SSN OR EDISON ID	
DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS	EMPLOYER/RETIREE GROUP: <input type="checkbox"/> UT <input type="checkbox"/> TBR <input type="checkbox"/> State <input type="checkbox"/> Local Ed <input type="checkbox"/> Local Gov	DESIRED EFFECTIVE DATE		
HOME ADDRESS			CITY	ST	ZIP CODE COUNTY	
PART 3: DENTAL COVERAGE SELECTION						
SELECT A PLAN <input type="checkbox"/> Delta Dental Dental Preferred Provider Organization (DPPO) <input type="checkbox"/> Cigna Dental Health Maintenance Organization — You MUST select a general dentist from the list of participating network dentists			SELECT A DENTAL PREMIUM LEVEL <input type="checkbox"/> self only <input type="checkbox"/> self + spouse <input type="checkbox"/> self + child(ren) <input type="checkbox"/> self + spouse + child(ren)			
PART 4: DEPENDENT INFORMATION — LIST ALL DEPENDENTS YOU WISH TO COVER (attach a separate sheet if necessary)						
SOCIAL SECURITY NUMBER	NAME (LAST, FIRST, MI)		BIRTHDATE	GENDER	RELATIONSHIP	ACQUIRE DATE *
				<input type="checkbox"/> M <input type="checkbox"/> F		
				<input type="checkbox"/> M <input type="checkbox"/> F		
				<input type="checkbox"/> M <input type="checkbox"/> F		
				<input type="checkbox"/> M <input type="checkbox"/> F		
<p>* The acquire date is the date of marriage, birth, adoption or guardianship. <input type="checkbox"/> A separate sheet with more dependents is attached</p> <p>Proof of a dependent's eligibility must be submitted with this application for all new dependents.</p>						
PART 5: AUTHORIZATION						
<p>I confirm that the information above is true. I understand my dental selection is effective until the end of the plan year (December 31), subject to plan eligibility criteria, and that I cannot change insurance plans or carriers during the plan year. If I experience a qualifying event mid-year, I may be eligible for changes in enrollment of plan members and dependents as a special enrollment. I understand that submission of fraudulent information may lead to consequences including cancellation of insurance or possible criminal penalties. If my dependents lose eligibility, I know that I must tell Benefits Administration within one calendar month. If I do not, then I will have to pay the plan back for my dependent's claims.</p>						
SIGNATURE			DATE	HOME PHONE		
EMAIL ADDRESS						



DEPENDENT ELIGIBILITY

Definitions and Required Documents

**PARTNERS
FOR HEALTH**

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	You will need to provide a document proving marital relationship AND one document from the additional documents list below:
		Proof of Marital Relationship <ul style="list-style-type: none"> • Government-issued marriage certificate or license • Naturalization papers indicating marital status
		Additional Documents <ul style="list-style-type: none"> • Bank Statement issued within the last six months with both names; or • Mortgage Statement issued within the last six months with both names; or • Residential Lease Agreement within the current terms with both names; or • Credit Card Statement issued within the last six months with both names; or • Property Tax Statement issued within the last 12 months with both names; or • The first page of most recent Federal Tax Return filed showing “married filing jointly” or “married filing separately” with the name of the spouse provided thereon; submit page 1 of the return with the income figures blacked out
		If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child’s birth certificate (will accept mother’s copy for newborn); or
		Certificate of Report of Birth (DS-1350); or
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or
		Certification of Birth Abroad (FS-545)
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	Final court order granting adoption; or
		International adoption papers from country of adoption; or
		Court order placing child in custody of member for purpose of adoption
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse, or documents determined by BA to be the legal equivalent
Disabled dependent	A dependent of any age who falls under one of the categories previously listed and due to a mental or physical disability, is unable to earn a living. The dependent’s disability must have begun before age 26 and while covered under a state-sponsored plan.	<p>Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent’s 26th birthday.</p> <p>The insurance carrier will review the form, make a determination and provide BA with documentation once a determination has been made. If approved for incapacity, the child will continue the same coverage.</p>
Child under age 26 placed for guardianship, custody or conservatorship with the head of contract* (placement order active or expired due to age of majority)	A child under age 26 for whom the head of contract is or has been the legal guardian, custodian or conservator	Valid order by a court of competent jurisdiction (placement order) establishing guardianship, custody or conservatorship arrangement between child and head of contract; and an attestation signed by the head of contract upon initial enrollment and upon request

*Head of contract is the person who elects coverage and has authority to change coverage elections.

Never send original documents. Please mark out or black out any Social Security numbers and any personal financial information on the copies of your documents BEFORE you return them.