2018 OCEA SPECIAL ENROLLMENT SUPPLEMENTAL TERM LIFE ONLY FORM B

MAY 7–JUNE 29, 2018

OCEA HEALTH & WELFARE TRUST • 830 N. ROSS ST., SANTA ANA, CA 92701 • (714) 835-3355 • WWW.OCEA.ORG

IMPORTANT: These benefits are available to OCEA members only (at additional premiums). Join OCEA now to take advantage of these benefits.

EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)		EMPLOYEE ID NUMBER
SOCIAL SECURITY NUMBER – –	BIRTH DATE / /	❑ MARRIED ❑ UNMARRIED
HOME ADDRESS		❑ FEMALE ❑ MALE
CITY STATE ZIP		REASON I AM SUBMITTING THIS FORM: ❑ INITIAL ENROLLMENT ❑ SPECIAL ENROLLMENT
HOME PHONE	CELL PHONE	
WORK PHONE	HOME EMAIL	

*SUPPLEMENTAL LIFE INSURANCE (COVERAGE MAY REQUIRE EVIDENCE OF INSURABILITY)

❑ I wish to enroll in the OCEA SUPPLEMENTAL LIFE INSURANCE PLAN.
***Includes AD&D & Burial Benefit for Active members.**

GROSS BIWEEKLY SALARY

I now have:
- ❑ 1 x base annual salary
- ❑ 2 x base annual salary
- ❑ 3 x base annual salary
- ❑ Dependent life insurance**

I apply for:
- ❑ 1 x base annual salary
- ❑ 2 x base annual salary
- ❑ 3 x base annual salary
- ❑ 4 x base annual salary
- ❑ 5 x base annual salary
- ❑ Dependent life insurance**

It is the sole responsibility of the employee to notify OCEA in writing when a dependent ceases to be eligible for coverage. Payroll deductions will continue until written notification is received at OCEA's Headquarters.

MEDICAL HISTORY STATEMENT

- ❑ I would like OCEA to mail the required Medical History Statement to my home.
- ❑ I will complete the required Medical History Statement online. Visit www.standard.com/mhs
  Note: ***You will need to enter OCEA's policy #608843***
- ❑ I do not believe a Medical History Statement is required for my enrollment.

BENEFICIARY DESIGNATION—FOR THESE BENEFITS ONLY

Beneficiary designations cancel any previous designations for Supplemental Life Insurance.

PRIMARY—FULL NAME	ADDRESS	SOCIAL SECURITY #	RELATIONSHIP	% OF BENEFIT

CONTINGENT—FULL NAME	ADDRESS	SOCIAL SECURITY #	RELATIONSHIP	% OF BENEFIT

(CONTINUED ON REVERSE SIDE)

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Costs

Biweekly Earnings	Coverage	Twice-Monthly Deduction
Less than $1,500	**$50,000**	**$1.63**
$1,500-$1,999	**$75,000**	**$2.44**
$2,000 or more	**$100,000**	**$3.25**

❑ I wish to enroll in the OCEA VOLUNTARY AD&D PLAN.	GROSS BIWEEKLY SALARY

BENEFICIARY DESIGNATION—FOR THIS BENEFIT ONLY

Beneficiary designations cancel any previous designations for Voluntary AD&D.

PRIMARY—FULL NAME	ADDRESS	SOCIAL SECURITY #	RELATIONSHIP	% OF BENEFIT

CONTINGENT—FULL NAME	ADDRESS	SOCIAL SECURITY #	RELATIONSHIP	% OF BENEFIT

AUTHORIZATION, SIGNATURE AND DISCLOSURE

I hereby authorize payroll deduction of the premiums associated with the above benefits from my paycheck. I agree that I am solely responsible for such premium payments whether premiums are payroll-deducted or paid otherwise. I agree that any unpaid premiums, including those unpaid through administrative error or non-issuance of a paycheck, will be reimbursed to the OCEA Health & Welfare Trust upon demand.

In most cases, to cancel supplemental benefit plan coverage, it is the sole responsibility of the employee to notify OCEA in writing. Payroll deductions will continue until written notification is received at OCEA's Headquarters.

I have read and reviewed the foregoing information and acknowledge that the selection(s) correctly reflect my enrollment choice(s). I represent that all statements herein are true and complete to the best of my knowledge and belief. I understand and acknowledge that any person who knowingly and with intent to defraud an insurance company files a statement of claim containing any materially false information or conceals information for such purpose commits a crime.

↳ _____

EMPLOYEE SIGNATURE **DATE**

FOR OFFICE USE ONLY

	Code	**Effective Date**	Membership Date
Supplemental Life	_____	_____	_____
Voluntary AD&D	_____	_____	