2024 OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM

MUST BE COMPLETED AND RETURNED TO OCEA WITHIN 45 DAYS OF HIRE DATE, TRANSFER INTO AN OCEA-REPRESENTED UNIT, PART-TIME TO FULL-TIME EMPLOYMENT STATUS CHANGE, DURING OPEN ENROLLMENT, OR 31 DAYS UPON A FAMILY STATUS CHANGE.

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

*These benefits are provided at **NO COST** to OCEA-represented employees in County Units, Court, Law Library, and Fire Authority.*

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 ❑ OPEN ENROLLMENT ❑ FAMILY STATUS CHANGE
HOME PHONE	CELL PHONE	
WORK PHONE	HOME EMAIL	

VISION SERVICE PLAN for Employee Only is included for full-time employees only in Option 1 or Option 2.
BASIC DISABILITY is included for employees in Option 1, Option 2 or Option 3.

OPTION PACKAGE

❑ EMPLOYEE ONLY (Option 1) ❑ EMPLOYEE WITH DEPENDENTS (Option 2) ❑ PART-TIME EMPLOYEE (Option 3)

DENTAL PLAN

❑ DELTA DENTAL PPO PLAN A (Employee only, no dependents) ❑ DELTACARE USA CAM50 (DHMO) **DENTAL OFFICE # (DHMO ONLY)** ________

To locate a DeltaCare USA dentist, visit the online DeltaCare USA directory at deltadentalins.com. You may also request the most current listing of DeltaCare USA dentists by calling toll-free at (800) 422-4234.

Complete this section if you want to enroll your dependents under the DeltaCare USA CAM50 (DHMO) dental plan:

	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	BIRTH DATE	DENTAL OFFICE # (DHMO ONLY)
SPOUSE		– –	/ /	
DEPENDENT		– –	/ /	
DEPENDENT		– –	/ /	
DEPENDENT		– –	/ /	
DEPENDENT		– –	/ /	

LIFE INSURANCE BENEFICIARY DESIGNATION (BENEFICIARY DESIGNATIONS CANCEL ANY PREVIOUS DESIGNATIONS)

$25,000 POLICY PROVIDED AT NO COST BY THE HEALTH & WELFARE TRUST

FULL NAME OF BENEFICIARY (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP
ADDRESS (OR ADDRESSES)	PHONE NUMBER		% OF BENEFIT

DHMO NOTICE: IF YOU ARE ENROLLING IN A DHMO, BY SIGNING THIS DOCUMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE THE BINDING ARBITRATION SECTION OF YOUR EVIDENCE OF COVERAGE.

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	H&W Option	Effective Date	Hire Date	Transfer Date	Initial	Membership Date