2024 OCEA SUPPLEMENTAL DENTAL & VISION BENEFITS ENROLLMENT FORM

MUST BE COMPLETED AND RETURNED TO OCEA WITHIN THE FIRST 31 DAYS OF OCEA MEMBERSHIP, DURING OPEN ENROLLMENT, OR UPON A FAMILY STATUS CHANGE.

If you are a new hire, or recently transferred into an OCEA represented unit, you should ALSO complete and return the enclosed OCEA HEALTH & WELFARE ENROLLMENT FORM.

OCEA HEALTH & WELFARE TRUST • 830 N. ROSS ST., SANTA ANA, CA 92701 • (714) 835-3355 • OCEA.ORG • BENEFITS@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 ❑ OPEN ENROLLMENT ❑ FAMILY STATUS CHANGE ❑ RETIREE
HOME PHONE	CELL PHONE	
WORK PHONE	HOME EMAIL	

DENTAL PLAN (Check one plan if desired)

❑ DELTA DENTAL PPO PLAN A+ (Not available to Retirees) ❑ DELTACARE USA CAM49 (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.

Dependent Enrollment for Supplemental Dental Plans

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

(CONTINUED ON REVERSE SIDE)

VSP VISION PLAN

VSP coverage is automatic for employees only in Health & Welfare Option 1 or Option 2.

- ❑ I wish to enroll in the VSP PLAN without dependents. **I am not enrolled in Health & Welfare Option 1 or Option 2 (or I am not in a Health & Welfare unit).**
- ❑ I wish to enroll in the VSP PLAN with dependents (permissible regardless of unit).

	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	BIRTH DATE
SPOUSE		– –	/ /
DEPENDENT		– –	/ /
DEPENDENT		– –	/ /
DEPENDENT		– –	/ /
DEPENDENT		– –	/ /
DEPENDENT		– –	/ /
DEPENDENT		– –	/ /

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.

If I enroll in a dental and/or vision plan, I understand that provided I remain employed I must maintain the coverage throughout the plan year. (I can still make changes during open enrollment periods, and under other circumstances outlined in plan documents.)

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

	Code	Effective Date	Membership Date
Delta Dental PPO Plan A+	_____	_____	_____
DeltaCare USA CAM49 (DHMO)	_____	_____	
Vision Service Plan	_____	_____	