2024 OCEA SUPPLEMENTAL LIFE & DISABILITY 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	

*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:	I am applying for:
❑ 1 x base annual salary	❑ 1 x base annual salary
❑ 2 x base annual salary	❑ 2 x base annual salary
❑ 3 x base annual salary	❑ 3 x base annual salary
❑ 4 x base annual salary	❑ 4 x base annual salary
❑ 5 x base annual salary	❑ 5 x base annual salary
❑ Dependent life insurance**	❑ Dependent life insurance**
	❑ Retiree 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 standard.com/mhs
*Note: **You will need to enter OCEA's policy #608843***

BENEFICIARY DESIGNATION—FOR THESE BENEFITS ONLY

Beneficiary designations cancel any previous designations for Supplemental Life Insurance.

PRIMARY—LAST, FIRST MI	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	TELEPHONE	% OF BENEFIT

CONTINGENT—LAST, FIRST MI	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	TELEPHONE	% OF BENEFIT

(CONTINUED ON REVERSE SIDE)

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)
(Not available to Retirees)

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 THESE BENEFITS ONLY

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

PRIMARY—LAST, FIRST MI	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	TELEPHONE	% OF BENEFIT

CONTINGENT—LAST, FIRST MI	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP	TELEPHONE	% OF BENEFIT

SUPPLEMENTAL DISABILITY PLAN
(Not available to Retirees)

❑ I wish to enroll in the OCEA SUPPLEMENTAL DISABILITY PLAN. ❑ **Level One** OR ❑ **Level Two**	GROSS BIWEEKLY SALARY

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	_____	_____	_____
Disability Plan	_____	_____	