2024 OCEA BENEFITS ENROLLMENT FORM

ACCIDENT INSURANCE | CRITICAL ILLNESS INSURANCE | HOSPITAL INDEMNITY INSURANCE

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
HOME PHONE	CELL PHONE	
WORK PHONE	HOME EMAIL	
SPOUSE FULL NAME	SPOUSE BIRTH DATE / /	IS YOUR SPOUSE GAINFULLY EMPLOYED OR CAPABLE OF PERFORMING THE MATERIAL DUTIES OF AN OCCUPATION? ❑ YES ❑ NO

ACCIDENT INSURANCE

❑ I wish to enroll in the ACCIDENT INSURANCE PLAN.

- ❑ You only
- ❑ You and your Spouse
- ❑ You and your Child(ren) (no Spouse)
- ❑ You, your Spouse, and your Child(ren)

ACCIDENT, CRITICAL ILLNESS, & HOSPITAL INDEMNITY INSURANCES

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.

CRITICAL ILLNESS INSURANCE

❑ I wish to enroll in the CRITICAL ILLNESS INSURANCE PLAN.

A. Do you have major medical or other minimum essential insurance that provides medical, hospital, and surgical coverage? (If the answer is "No", you are not eligible for Critical Illness.)

❑ Yes ❑ No

B. Are you age 65 or older? (The plan must be in effect before your 65th birthday or you are not eligible for Critical Illness Insurance.)

❑ Yes ❑ No

MEMBER*

You must choose one of the following options:

- ❑ $10,000
- ❑ $20,000
- ❑ $30,000

SPOUSE (COVERAGE CANNOT EXCEED 50% OF MEMBERS COVERED AMOUNT)

You must choose one of the following options:

- ❑ $5,000
- ❑ $10,000
- ❑ $15,000
- ❑ Decline Critical Illness for your Spouse

**** ELIGIBLE CHILD(REN) ARE AUTOMATICALLY COVERED AT 50% OF YOUR COVERAGE AMOUNT.***

(CONTINUED ON REVERSE SIDE)

HOSPITAL INDEMNITY INSURANCE

❑ I wish to enroll in the HOSPITAL INDEMNITY INSURANCE PLAN.

A. Do you have major medical or other minimum essential insurance that provides medical, hospital, and surgical coverage? (If the answer is "No", you are not eligible for Hospital Indemnity.)

❑ Yes ❑ No

B. Are you age 65 or older? (The plan must be in effect before your 65th birthday or you are not eligible for Hospital Indemnity Insurance.)

❑ Yes ❑ No

Choose one of the following options:

❑ You only

❑ You and your Spouse

❑ You and your Child(ren) (no Spouse)

❑ You, your Spouse, and your Child(ren)

For Accident, Critical Illness, Hospital Indemnity Insurance:

These benefits are under limited benefit insurance policies. These policies are a supplement to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

AUTHORIZATION, SIGNATURE AND DISCLOSURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

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
Accident	_____	_____	_____
Critical Illness	_____	_____	
Hospital Indemnity	_____	_____	

JANUARY 1–DECEMBER 31, 2024

ACCIDENT INSURANCE

	Biweekly
Member only	$ 3.71
Member and Spouse	6.18
Member and Child(ren)	6.80
Member, Spouse, and your Child(ren)	10.78

CRITICAL ILLNESS INSURANCE

	AGE BASED Biweekly					
COVERAGE AMOUNTS	18-29	30-39	40-49	50-59	60-69	70+
Member $10,000	**$1.30**	**$1.80**	**$3.50**	**$6.80**	**$12.30**	**$31.10**
Member $10,000 Spouse $5,000	$1.95	$2.70	$5.25	$10.20	$18.45	$46.65
Member $20,000	**$2.60**	**$3.60**	**$7.00**	**$13.60**	**$24.60**	**$62.20**
Member $20,000 Spouse $5,000	$3.25	$4.50	$8.75	$17.00	$30.75	$77.75
Member $20,000 Spouse $10,000	$3.90	$5.40	$10.50	$20.40	$36.90	$93.30
Member $30,000	**$3.90**	**$5.40**	**$10.50**	**$20.40**	**$36.90**	**$93.30**
Member $30,000 Spouse $5,000	$4.55	$6.30	$12.25	$23.80	$43.05	$108.85
Member $30,000 Spouse $10,000	$5.20	$7.20	$14.00	$27.20	$49.20	$124.40
Member $30,000 Spouse $15,000	$5.85	$8.10	$15.75	$30.60	$55.35	$139.95

HOSPITAL INDEMNITY INSURANCE

	Biweekly
Member only	$ 7.38
Member and Spouse	12.60
Member and Child(ren)	10.28
Member, Spouse, and your Child(ren)	18.41