VOLUNTARY AD&D

2026

OCEA H&W TRUST
SUPPLEMENTAL BENEFITS
ENROLLMENT FORM

AN OCEA MEMBER MAY ENROLL IN THE SUPPLEMENTAL VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT PLAN AT ANY TIME DURING THE YEAR.

*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 – –	DATE OF BIRTH / /	❑ MARRIED ❑ UNMARRIED ❑ DOMESTIC PARTNERSHIP	
HOME ADDRESS			❑ FEMALE ❑ MALE
CITY	STATE	ZIP	HOME EMAIL
HOME PHONE	CELL PHONE		WORK PHONE

SUPPLEMENTAL VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) | NOT AVAILABLE TO RETIREES

❑ I WISH TO ENROLL IN THE SUPPLEMENTAL VOLUNTARY AD&D PLAN.	GROSS BIWEEKLY SALARY

BENEFICIARY DESIGNATION—FOR THIS BENEFIT ONLY

BENEFICIARY DESIGNATIONS CANCEL ANY PREVIOUS DESIGNATIONS FOR VOLUNTARY AD&D

PRIMARY—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
		/ /	– –			
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CONTINGENT—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
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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.

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EMPLOYEE SIGNATURE **DATE**

VOLUNTARY AD&D

ADDITIONAL **PRIMARY** BENEFICIARY DESIGNATIONS

2026

OCEA H&W TRUST SUPPLEMENTAL BENEFITS ENROLLMENT FORM

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PRIMARY—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
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EMPLOYEE NAME **DATE OF BIRTH** **EMPLOYEE SIGNATURE** **DATE**

VOLUNTARY AD&D
ADDITIONAL **CONTINGENT** BENEFICIARY DESIGNATIONS

2026

OCEA H&W TRUST SUPPLEMENTAL BENEFITS ENROLLMENT FORM

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EMPLOYEE NAME **DATE OF BIRTH** **EMPLOYEE SIGNATURE** **DATE**