DISABILITY

2026

OCEA H&W TRUST
SUPPLEMENTAL BENEFITS
ENROLLMENT FORM

MUST BE **COMPLETED AND RETURNED** TO OCEA WITHIN THE FIRST **31 DAYS** FROM OCEA MEMBERSHIP | DURING OPEN ENROLLMENT | OR WITH EVIDENCE OF INSURABILITY APPROVAL

*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

REASON I AM SUBMITTING THIS FORM

❑ **INITIAL ENROLLMENT** ❑ **OPEN ENROLLMENT**

SUPPLEMENTAL DISABILITY PLAN | COVERAGE MAY REQUIRE EVIDENCE OF INSURABILITY | NOT AVAILABLE TO RETIREES

I WISH TO ENROLL IN THE SUPPLEMENTAL DISABILITY PLAN. ❑ **LEVEL ONE** OR ❑ **LEVEL TWO**	GROSS BIWEEKLY SALARY

MEDICAL HISTORY STATEMENT

❑ I would like OCEA to mail the required Medical History Statement to my home.

❑ I will find the required Medical History Statement online at ocea.org/benefits and submit to OCEA.

NOTE: You will need to enter OCEA's policy #608843

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**