2026 OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM

MUST BE **COMPLETED AND RETURNED** TO OCEA WITHIN **45 DAYS** FROM HIRE DATE, TRANSFER INTO AN OCEA-REPRESENTED UNIT, PART-TIME TO FULL-TIME EMPLOYMENT STATUS CHANGE | DURING OPEN ENROLLMENT | OR **31 DAYS** UPON A FAMILY STATUS CHANGE.

*These benefits are provided at **NO COST** to OCEA-represented employees in County Units, Superior Court, Law Library, and Fire Authority.*

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** ❑ **FAMILY STATUS CHANGE**

CHOOSE AN OPTION PACKAGE

OPTION 1 | PPO OR DHMO	**OPTION 2** | DHMO ONLY	**OPTION 3** | PPO ONLY
❑ **EMPLOYEE ONLY**	❑ **EMPLOYEE WITH DEPENDENTS**	❑ **PART-TIME EMPLOYEE**

VISION SERVICE PLAN is included for full-time employees only in Option 1 or Option 2.

BASIC LIFE and BASIC DISABILITY are included for employees in Option 1, Option 2, or Option 3.

DENTAL PLAN

❑ **DELTA DENTAL PPO PLAN A** | EMPLOYEE ONLY—NO DEPENDENTS	❑ **DELTACARE USA CAM50 (DHMO)**	
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.	**DENTAL OFFICE # (DHMO ONLY)**	

COMPLETE THIS SECTION IF YOU WANT TO ENROLL YOUR DEPENDENTS UNDER THE DELTACARE USA CAM50 (DHMO) DENTAL PLAN

RELATIONSHIP	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DENTAL OFFICE # (DHMO ONLY)
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— OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM CONTINUED ON NEXT PAGE —

— OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM CONTINUED FROM PREVIOUS PAGE —

LIFE INSURANCE BENEFICIARY DESIGNATION
$25,000 POLICY PROVIDED AT NO COST BY THE HEALTH & WELFARE TRUST

BENEFICIARY DESIGNATIONS
CANCEL ANY PREVIOUS DESIGNATIONS

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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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.

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EMPLOYEE SIGNATURE **DATE**

ADDITIONAL DENTAL DEPENDENTS

2026

OCEA H&W TRUST
HEALTH & WELFARE BENEFITS
ENROLLMENT FORM

RELATIONSHIP	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DENTAL OFFICE # (DHMO ONLY)
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RELATIONSHIP	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DENTAL OFFICE # (DHMO ONLY)
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RELATIONSHIP	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DENTAL OFFICE # (DHMO ONLY)
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EMPLOYEE NAME **DATE OF BIRTH** **EMPLOYEE SIGNATURE** **DATE**

$25,000 LIFE INSURANCE POLICY

ADDITIONAL **PRIMARY** BENEFICIARY DESIGNATIONS

2026

OCEA H&W TRUST
HEALTH & WELFARE BENEFITS
ENROLLMENT FORM

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

$25,000 LIFE INSURANCE POLICY

ADDITIONAL **CONTINGENT** BENEFICIARY DESIGNATIONS

2026

OCEA H&W TRUST
HEALTH & WELFARE BENEFITS
ENROLLMENT FORM

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