LIFE INSURANCE 2026

OCEA H&W TRUST
SUPPLEMENTAL BENEFITS
ENROLLMENT FORM

MUST BE **COMPLETED AND RETURNED** TO OCEA WITHIN THE FIRST **31 DAYS** FROM OCEA MEMBERSHIP OR UPON A FAMILY STATUS CHANGE | 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** ❑ **FAMILY STATUS CHANGE** ❑ **RETIREE**

SUPPLEMENTAL LIFE INSURANCE | COVERAGE MAY REQUIRE EVIDENCE OF INSURABILITY

I WISH TO ENROLL IN THE SUPPLEMENTAL LIFE INSURANCE PLAN.

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*
❑ Not currently enrolled	❑ Retiree life insurance

GROSS BIWEEKLY SALARY

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 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

BENEFICIARY DESIGNATION—FOR THIS BENEFIT ONLY

BENEFICIARY DESIGNATIONS CANCEL ANY PREVIOUS DESIGNATIONS FOR SUPPLEMENTAL LIFE INSURANCE

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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— SUPPLEMENTAL LIFE INSURANCE ENROLLMENT FORM CONTINUED ON NEXT PAGE —

— SUPPLEMENTAL LIFE INSURANCE ENROLLMENT FORM CONTINUED FROM PREVIOUS PAGE —

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**

LIFE INSURANCE

ADDITIONAL **PRIMARY** BENEFICIARY DESIGNATIONS

2026

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

LIFE INSURANCE

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**