VISION

2026

OCEA H&W TRUST
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 DURING OPEN ENROLLMENT

*These benefits are available to **OCEA MEMBERS ONLY (AT ADDITIONAL PREMIUMS)**. Join OCEA now to take advantage of these benefits!*

IF YOU ARE A NEW HIRE, OR RECENTLY TRANSFERRED INTO AN OCEA-REPRESENTED UNIT, YOU SHOULD ALSO SUBMIT THE OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM

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** ❑ **RETIREE**

VISION PLAN

VSP COVERAGE IS AUTOMATIC FOR **EMPLOYEES ONLY** IN HEALTH & WELFARE OPTION 1 OR OPTION 2.

❑ **I WISH TO ENROLL IN THE VSP PLAN WITHOUT DEPENDENTS**
I am not enrolled in Health & Welfare Option 1 or Option 2 (or I am not in a Health & Welfare unit).

❑ **I WISH TO ENROLL IN THE VSP PLAN WITH DEPENDENTS**
(Permissible regardless of unit.)

DEPENDENT ENROLLMENT FOR VISION PLAN

RELATIONSHIP	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH
		– –	/ /
		– –	/ /
		– –	/ /
		– –	/ /

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.

If I enroll in a vision plan, I understand that provided I remain employed I must maintain the coverage throughout the plan year. (I can still make changes during open enrollment periods, and under other circumstances outlined in plan documents.)

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**

ADDITIONAL VISION DEPENDENTS

2026

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RELATIONSHIP	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH
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		– –	/ /

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