# 2017 OCEA SUPPLEMENTAL BENEFITS ENROLLMENT—FORM B

**MUST BE COMPLETED AND RETURNED TO OCEA WITHIN THE FIRST 31 DAYS OF OCEA MEMBERSHIP, DURING OPEN ENROLLMENT, OR UPON A FAMILY STATUS CHANGE.**

**If you are a new hire, or recently transferred into an OCEA represented unit, you should ALSO complete and return the enclosed OCEA HEALTH & WELFARE ENROLLMENT FORM A.**

OCEA Health & Welfare Trust · 830 N. Ross Street, Santa Ana, CA 92701 · (714) 835-3355 · www.oceamember.org

*IMPORTANT: These benefits are available to OCEA members only (at additional premiums). Join OCEA now to take advantage of these benefits!*

## EMPLOYEE INFORMATION

EMPLOYEE ID NUMBER: _____

NAME (Last, First, MI)_____

REASON I AM SUBMITTING THIS FORM:

SOCIAL SECURITY NUMBER _____ - _____ - _____ F M (Circle one)

☐ INITIAL ENROLLMENT

HOME ADDRESS _____

☐ OPEN ENROLLMENT

CITY _____STATE _____ ZIP _____

☐ FAMILY STATUS CHANGE

PHONE (Home) (_____) _____ (Work) (_____) _____

☐ RETIREE

BIRTH DATE ____/____ /_____ ☐ MARRIED ☐ UNMARRIED E-mail address: _____

## DENTAL PLAN (Check one plan if desired)

☐ DELTA DENTAL PPO PLAN A+ (Not available to Retirees)

☐ DELTACARE CAM42 (DHMO) Dental Office # (DHMO only): _____

To locate a DeltaCare dentist, visit the online DeltaCare directory at www.deltadentalins.com.
You may also request the most current listing of DeltaCare dentists by calling toll-free at (800) 422-4234.

### Dependent Enrollment for Supplemental Dental Plans

| | NAME (Last, First, MI) | SOCIAL SEC. # | BIRTH DATE (mm/dd/yy) | DENTAL OFFICE # (DHMO only) |
|---|---|---|---|---|
| Spouse: | | | | |
| Dependent: | | | | |
| Dependent: | | | | |
| Dependent: | | | | |
| Dependent: | | | | |

## SUPPLEMENTAL DISABILITY PLAN (Not available to Retirees)

☐ I wish to enroll in the OCEA supplemental disability plan. My gross biweekly salary: $_____ ☐ Level 1 ☐ Level 2

## VSP 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).

| | NAME (Last, First, MI) | SOCIAL SEC. # | BIRTH DATE (mm/dd/yy) |
|---|---|---|---|
| Spouse: | | | |
| Dependent: | | | |
| Dependent: | | | |
| Dependent: | | | |
| Dependent: | | | |

*(continued on reverse side)*

## SUPPLEMENTAL LIFE INSURANCE **(Coverage requires evidence of insurability)**

☐ I wish to enroll in the OCEA Supplemental Life Insurance Plan.

My gross biweekly salary: $_____

| I now have: | I apply 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 |
| ☐ Dependent life insurance* | ☐ Dependent life insurance* |
| | ☐ Retiree life insurance |

**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.*

NAME OF BENEFICIARY (OR BENEFICIARIES): _____

RELATIONSHIP(S): _____

ADDRESS (OR ADDRESSES):_____

## VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT

**(Beneficiary designations cancel any previous designations)**

☐ I wish to enroll in the OCEA voluntary AD&D plan. My gross biweekly salary: $_____

NAME OF BENEFICIARY (OR BENEFICIARIES): _____

RELATIONSHIP(S): _____

ADDRESS (OR ADDRESSES):_____

## AUTHORIZATION, SIGNATURE AND DISCLOSURE

I hereby authorize payroll deductions 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 dental 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.)

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.*

**Employee Signature** _____ **Date** _____

**FOR OFFICE USE ONLY**

| | Code | Effective Date |
|---|---|---|
| Delta Dental PPO Plan A+ | _____ | _____ |
| DeltaCare CAM42 (DHMO) | _____ | _____ |
| Supplemental Life | _____ | _____ |
| Voluntary AD&D | _____ | _____ |
| Vision Service Plan | _____ | _____ |
| Supplemental Disability | _____ | _____ |

Membership Date: _____