2017 OCEA HEALTH & WELFARE BENEFITS ENROLLMENT—FORM A

MUST BE COMPLETED AND RETURNED TO OCEA WITHIN 31 DAYS OF HIRE DATE, DURING OPEN ENROLLMENT, OR UPON A FAMILY STATUS CHANGE.

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

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

EMPLOYEE INFORMATION

NAME (Last, First, MI)_____ EMPLOYEE ID NUMBER: _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ F M (Circle one) REASON I AM SUBMITTING THIS FORM:

HOME ADDRESS _____ ☐ INITIAL ENROLLMENT

CITY _____STATE _____ ZIP _____ ☐ OPEN ENROLLMENT

PHONE (Home) (_____) _____ (Work) (_____) _____ ☐ FAMILY STATUS CHANGE

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

OPTION PACKAGE

☐ EMPLOYEE ONLY (Option 1) ☐ EMPLOYEE WITH DEPENDENTS (Option 2) ☐ PART-TIME EMPLOYEE (Option 3)

DENTAL PLAN

☐ DELTA DENTAL PPO PLAN A (Employee only, no dependents) ☐ DELTACARE CAM43 (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.

Complete this section if you want to enroll your dependents under the DeltaCare CAM43 (DHMO) dental plan:

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

LIFE INSURANCE BENEFICIARY DESIGNATION (Cancels any previous designations) — $25,000 policy provided at no cost by the Health and Welfare Trust

NAME OF BENEFICIARY (OR BENEFICIARIES) **AND** RELATIONSHIP(S): _____

ADDRESS (OR ADDRESSES):_____

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	H&W Option	Effective Date	Hire Date	Transfer Date	Initial	Membership Date