

2011 OCEA SUPPLEMENTAL BENEFITS ENROLLMENT—FORM B

MUST BE COMPLETED AND RETURNED TO OCEA WITHIN THE FIRST 30 DAYS OF OCEA MEMBERSHIP, OR DURING OPEN ENROLLMENT.

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

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: _____ RETIREE

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:
- 1 x base annual salary
 - 2 x base annual salary
 - 3 x base annual salary
 - Dependent life insurance

- I apply for:
- 1 x base annual salary
 - 2 x base annual salary
 - 3 x base annual salary
 - Dependent life insurance
 - Retiree life insurance

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.

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+	_____	_____	Membership Date: _____
DeltaCare CAM42 (DHMO)	_____	_____	
Supplemental Life	_____	_____	
Voluntary AD&D	_____	_____	
Vision Service Plan	_____	_____	
Supplemental Disability	_____	_____	