CRITICAL ILLNESS | HOSPITAL INDEMNITY

2025

OCEA SUPPLEMENTAL BENEFITS ENROLLMENT FORM

MUST BE **COMPLETED AND RETURNED** TO OCEA WITHIN THE FIRST **31 DAYS** FROM OCEA MEMBERSHIP | OR DURING OPEN ENROLLMENT

*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
HOME ADDRESS		❑ FEMALE ❑ MALE
CITY	STATE ZIP	HOME EMAIL
HOME PHONE	CELL PHONE	WORK PHONE
SPOUSE FULL NAME (LAST, FIRST, MI)		SPOUSE DATE OF BIRTH / /

REASON I AM SUBMITTING THIS FORM

❑ **INITIAL ENROLLMENT** ❑ **OPEN ENROLLMENT**

CRITICAL ILLNESS INSURANCE

❑ **I WISH TO ENROLL IN THE CRITICAL ILLNESS INSURANCE PLAN.**

❑ **YOU ONLY**

❑ **YOU AND YOUR SPOUSE**

MEMBER*

YOU MUST CHOOSE ONE OF THE FOLLOWING OPTIONS

❑ **$10,000**
❑ **$20,000**
❑ **$30,000**

SPOUSE COVERAGE CANNOT EXCEED 50% OF MEMBERS COVERED AMOUNT

SPOUSE

YOU MUST CHOOSE ONE OF THE FOLLOWING OPTIONS

❑ **$5,000**
❑ **$10,000**
❑ **$15,000**
❑ **DECLINE CRITICAL ILLNESS COVERAGE FOR YOUR SPOUSE**

A. Do you have major medical or other minimum essential insurance that provides medical, hospital, and surgical coverage? (If the answer is "No", you are not eligible for Critical Illness.)

❑ **YES** ❑ **NO**

B. Are you age 65 or older? (The plan must be in effect before your 65th birthday or you are not eligible for Critical Illness Insurance.)

❑ **YES** ❑ **NO**

** ELIGIBLE CHILD(REN) ARE AUTOMATICALLY COVERED AT 50% OF YOUR COVERAGE AMOUNT.*

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.

— CRITICAL ILLNESS AND HOSPITAL INDEMNITY ENROLLMENT FORM CONTINUED ON NEXT PAGE —

— CRITICAL ILLNESS AND HOSPITAL INDEMNITY INSURANCE ENROLLMENT FORM CONTINUED FROM PREVIOUS PAGE —

HOSPITAL INDEMNITY INSURANCE

❑ **I WISH TO ENROLL IN THE HOSPITAL INDEMNITY INSURANCE PLAN.**

- ❑ **YOU ONLY**
- ❑ **YOU AND YOUR SPOUSE**
- ❑ **YOU AND YOU CHILD(REN) (NO SPOUSE)**
- ❑ **YOU, YOUR SPOUSE, AND YOUR CHILD(REN)**

A. Do you have major medical or other minimum essential insurance that provides medical, hospital, and surgical coverage? (If the answer is "No," you are not eligible for Hospital Indemnity.)

❑ **YES** ❑ **NO**

B. Are you age 65 or older? (The plan must be in effect before your 65th birthday or you are not eligible for Hospital Indemnity.)

❑ **YES** ❑ **NO**

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.

IS YOUR SPOUSE GAINFULLY EMPLOYED OR CAPABLE OF PERFORMING THE MATERIAL DUTIES OF AN OCCUPATION?	❑ YES ❑ NO

These benefits are under limited benefit insurance policies. These policies are a supplement to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

AUTHORIZATION, SIGNATURE AND DISCLOSURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

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.

↳ _____

EMPLOYEE SIGNATURE **DATE**

FOR OFFICE USE ONLY

	CODE	EFFECTIVE DATE	MEMBERSHIP DATE
CRITICAL ILLNESS			
HOSPITAL INDEMNITY			