2025 OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM

MUST BE **COMPLETED AND RETURNED** TO OCEA WITHIN **45 DAYS** FROM HIRE DATE, TRANSFER INTO AN OCEA-REPRESENTED UNIT, PART-TIME TO FULL-TIME EMPLOYMENT STATUS CHANGE | DURING OPEN ENROLLMENT | OR **31 DAYS** UPON A FAMILY STATUS CHANGE.

*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 – –	DATE OF BIRTH / /		❑ MARRIED ❑ UNMARRIED
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

CHOOSE AN OPTION PACKAGE

OPTION 1 | PPO OR DHMO	OPTION 2 | DHMO ONLY	OPTION 3 | PPO ONLY
❑ EMPLOYEE ONLY	❑ EMPLOYEE WITH DEPENDENTS	❑ PART-TIME EMPLOYEE

VISION SERVICE PLAN for Employee Only is included for full-time employees only in Option 1 or Option 2.

BASIC LIFE and BASIC DISABILITY are included for employees in Option 1, Option 2, or Option 3.

DENTAL PLAN

❑ **DELTA DENTAL PPO PLAN A** | EMPLOYEE ONLY—NO DEPENDENTS

❑ **DELTACARE USA CAM50 (DHMO)**

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

DENTAL OFFICE # (DHMO ONLY):

COMPLETE THIS SECTION IF YOU WANT TO ENROLL YOUR DEPENDENTS UNDER THE DELTACARE USA CAM50 (DHMO) DENTAL PLAN:

RELATIONSHIP	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DENTAL OFFICE # (DHMO ONLY)
		– –	/ /	
		– –	/ /	
		– –	/ /	
		– –	/ /	
		– –	/ /	

LIFE INSURANCE BENEFICIARY DESIGNATION
$25,000 POLICY PROVIDED AT NO COST BY THE HEALTH & WELFARE TRUST

BENEFICIARY DESIGNATIONS CANCEL ANY PREVIOUS DESIGNATIONS

FULL NAME OF BENEFICIARY (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER – –	DATE OF BIRTH / /	RELATIONSHIP
ADDRESS (OR ADDRESSES)	PHONE NUMBER			% OF BENEFIT

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