UNION BENEFITS TRUST

HOW TO ENROLL IN YOUR BENEFITS

FOR

MEMBERS AT THEIR ONE-YEAR

ANNIVERSARY OF SERVICE

ENROLLMENT GUIDE

benefits

REVISED JUNE 2008

Dear Member,

Congratulations! You have almost reached your one-year anniversary of State employment and as a member of the Union Benefits Trust.

Right now, you need to review two insurance options and decide if you'd like to enroll.

Your choices are (for you, and if applicable, your spouse and/or children):

- Dental coverage (Preferred Choice PPO plan or Quality Dental indemnity plan, both offered through MetLife) and/or
- Vision coverage (EyeMed or VSP).

To enroll, complete and return the enclosed forms within 31 days of your anniversary date. Enrolling as soon as possible will help to ensure that your coverage begins quickly, usually the first of the month after your employment anniversary date. Before you enroll, please read up on plan details and networks; each plan will have costs at the time of service, but the Trust pays the monthly premium costs for you.

The enclosed plan booklet describes these benefits in full detail, along with the basic life, in which you are automatically enrolled (the Trust pays the cost for you). Please declare a beneficiary as soon as possible, using the form in this enrollment guide.

Remember you have only 31 days from the anniversary date to enroll in dental and vision plans; if you miss the deadline, you MUST wait until the next Trust-sponsored open enrollment to enroll for coverage the following July 1.

For questions not answered in your booklet please contact the Trust customer service at 614-508-2255 when calling from Columbus, or 800-228-5088 when calling from outside Columbus.

Also, check out the Trust's website at www.benefitstrust.org.

Keep your address current at your worksite: We mail all of these materials to your home, so please keep your address current with your Human Resources officer.

We look forward to serving you.

The Board and Staff of the Union Benefits Trust

DENTAL AND VISION ENROLLMENT & CHANGE FORM

Complete the following after reading the Trust's enrollment materials, and submit the signed, dated form to your Human Resources officer within 31 days of your one-year anniversary date of continuous State service or 31 days of your family/work status change.

☐ NEW ENROLLMENT ☐ FAMILY/ WORK STATUS CHANGE Date of change_____/_____/_____

☐ Marriage
☐ Birth, adoption, guardianship
☐ Switch from exempt to Union-represented
☐ Divorce
☐ Agency transfer

MEMBER

Last Name First Name MI SSN County

Street Address City State ZIP Code

Worksite Office Telephone Number Date of Birth

DENTAL

	Single	Family
☐ Preferred Choice	☐	☐
☐ Quality Dental	☐	☐
☐ Waive Dental coverage		

VISION

	Single	Family
☐ EyeMed	☐	☐
☐ VSP	☐	☐
☐ Waive Vision coverage		

DEPENDENTS

Updating dependent information? Make sure you mark the appropriate family status change box(es) above before completing the section below. Attach a separate sheet if necessary. List your spouse first, then your eligible dependent children.

First Name	Last Name *(if different from yours)*	SSN	Birthdate	Sex	Relation	Add to		Drop from	
					Spouse	D	V	D	V
					Child	D	V	D	V
					Child	D	V	D	V
					Child	D	V	D	V

You may be required to file an Affidavit for your dependents; talk with your HR officer about this. If needed, a copy of the Affidavit is on the back of this form.

I certify the above information to be accurate. I understand I must submit this form within the enrollment/change period as described in Trust enrollment materials, and that submitting the form prior to my anniversary/change date helps to ensure that coverage will begin the effective date as described in the plan booklets.

Member Signature Date

THIS SECTION TO BE COMPLETED BY AGENCY DESIGNEE:

Employee Appointment Date CBU Agency Effective Date

Signature of Agency Designee Date Designee Phone Number

You are responsible for verifying eligible dependents and providing the effective date.

rev 6/08

AFFIDAVIT OF DEPENDENT STATUS

County of ________________________________ , State of Ohio

I, ____, after first being duly cautioned and sworn, state that:

☐ My unmarried dependent age 19 to 23 is primarily dependent on me for maintenance and support and

attends the following accredited school: ____

Name: ____

school name

Social Security Number: ____________________________ Date of Birth: ____________________________

☐ My stepchild:

☐ lives in my home more than 51% of the time

Name: ____

Social Security Number: ____________________________ Date of Birth: ____________________________

☐ I am the legal guardian/foster parent or adoptive parent of:

Name: ____

Social Security Number: ____________________________ Date of Birth: ____________________________

Attach legal document of appointment as guardian, foster placement or adoption placement.

☐ My unmarried child over age 19 is incapable of self-support due to mental retardation, mental health or ________________ physical handicap and is primarily dependent upon me for maintenance and support:

Name: ____

Social Security Number: ____________________________ Date of Birth: ____________________________

Further affiant sayeth naught.

____ ____

Signature of Employee

Social Security Number

Sworn before me and subscribed to in my presence this

________ day of ______________________, 20 _______

Notary Public

____

____

NOTE: If dependent is your legal spouse, you do not need to complete the affidavit. If dependent is a child born to you, you do not need to complete the affidavit until your child reaches age 19, at which point you must file an affidavit.

6/08

BENEFICIARY DESIGNATION FORM

*PLEASE REMEMBER TO SIGN YOUR FORM. IT WILL BE RETURNED IF IT DOES NOT HAVE YOUR SIGNATURE ON IT. THANK YOU!

Name of Group Policy Holder: Union Benefits Trust

Group Policy Number: LG-01049

Name of Insured (Last, First, Middle Initial)

Address City

State ZIP Code

Please check all that apply:
- ☐ I am newly eligible
- ☐ I am changing my beneficiary information for:
  - ☐ Basic Group Life
  - ☐ Supplemental Group Life

Social Security Number Date of Birth (MM/DD/YY) Date Employed (MM/DD/YY)

PRIMARY BENEFICIARY(IES)

First Name Middle Initial Last Name Relationship to member DOB

Address Social Security Number % Share

First Name Middle Initial Last Name Relationship to member DOB

Address Social Security Number % Share

CONTINGENT BENEFICIARY(IES) (optional)

First Name Middle Initial Last Name Relationship to member DOB

Address Social Security Number % Share

First Name Middle Initial Last Name Relationship to member DOB

Address Social Security Number % Share

If above space is not suitable for the designation(s) you desire, or you are not sure how to name a beneficiary, see the instructions on the back of this form for more information.

*Member's signature Date

GL.99.430 (Ed. 6/2004)
Cat#15P175H

Please mail to: The Prudential Insurance Company of America
P. O. Box 5072 • Millville, NJ 08332-9931

The Basic Life Coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Contract Series 83500.

UNION BENEFITS TRUST

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

INSTRUCTIONS FOR NAMING BENEFICIARIES

1. To designate one person, insert the name and relationship in the spaces provided. If your beneficiary is not related to you, show relationship as "Friend."
2. If you wish to name your estate, insert "Estate" in the beneficiary name space.
3. To name more than one beneficiary — here are the most common examples:

Two beneficiaries:	John J. Jones, father and Mary R. Jones, mother
Three or more beneficiaries:	James O. Jones, brother; Peter I. Jones, brother; and Martha Jones, sister
Unnamed children:	My children living at my death from my marriage to Lois P. Jones
One contingent beneficiary:	Lois P. Jones, wife if living; otherwise Herbert I. Jones, son
More than one contingent beneficiary:	Lois P. Jones, wife, if living; otherwise Herbert I. Jones, son, Alice B. Jones, daughter and Ann Y. Jones, daughter
Unnamed children as contingent beneficiaries:	Lois P. Jones, wife, if living; otherwise my children living at my death from my marriage to said wife

If one of the above examples fits your wishes, insert your designation in the beneficiary name spaces, using the language of the selected example.

4. If none of the above is suitable, explain in the space below what is desired, or attach a note.

If you wish, you may indicate the percentage share designated to each primary beneficiary. The total for one or all primary beneficiaries must equal 100%. If no percentages are specified, the proceeds will be split evenly among those named. If no named beneficiary survives you, any amount of insurance will be made payable to the first of the following; Your (a) surviving spouse, (b) surviving child(ren) in equal shares, (c) surviving parents in equal shares, (d) surviving siblings in equal shares, (e) estate. If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.

DEFINITIONS. You may find the following definitions helpful in completing this form:

Primary Beneficiary(ies) - the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

Contingent Beneficiary(ies) - the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. Payment will be made in equal shares unless otherwise specified. In the event that a designated contingent beneficiary predeceases the insured, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

Call Prudential with questions: 800-778-3827

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Deadline Reminders

- Dental and/or vision enrollment - no later than 31 days from your anniversary date of hire!!! Coverage will begin the first of the month following your one-year anniversary date provided you enroll on time.
- Return your dental and vision enrollment form to your Human Resources officer. The Trust does not need a copy.
- Basic life beneficiary forms should be mailed to Prudential. You may change your beneficiary at any time, and you may also declare different beneficiaries for your basic life and supplemental life benefits.
- Established term employees should check with their Human Resources officers to determine enrollment and eligibility information.

What Comes Next

Open Enrollment

Coverage elected during open enrollment typically takes effect the following July 1.

Dental and vision coverage

If you miss the 31-day deadline, you will have to wait until the next Trust-sponsored open enrollment (usually held each spring) to elect your coverage. This is true for many life and work-related changes; check the enclosed plan booklet for more details on qualified changes that might occur outside of open enrollment. During open enrollment, you may switch your dental and vision elections.

How to enroll in supplemental and legal coverage

To enroll in these plans, complete enrollment forms (that will be included in your open enrollment packet or will be available on the Trust's website during open enrollment). To make sure your coverage begins on time (the following July 1), complete the form for the coverage you would like, and mail it as instructed. These forms are not submitted to the Trust or your worksite.

About the Trust

Since 1993, the Union Benefits Trust has offered benefits to approximately 42,000 Union-represented State employees. Current benefits include: dental, vision and life insurance benefits, Working Solutions and the legal service plan

Serving the Members

The Trust members are the 42,000 Union-represented State employees in:

- OCSEA/AFSCME Local 11
- District 1199/ Service Employees International Union (SEIU)
- Ohio State Troopers Association (OSTA)
- Fraternal Order of Police (FOP)/OLC
- State Council of Professional Educators (SCOPE) / Ohio Education Association (OEA) and
- Communication Workers of America (CWA).

Setting policy benefiting members and administering the assets of the Trust are a few of the Trustees' duties. The Trustees consist of representatives from the five Unions with the most State employees, and a representative of the State.

A full-time staff provides additional support to members. The staff offers professional assistance through expertise in benefits analysis, customer service and communication.

Where to Find Help Now

www.benefitstrust.org

General information about dental, vision, legal, basic and/or supplemental life insurance or Working Solutions. Or help with enrollment/eligibility

Benefits Trust

614-508-2255 or 800-228-5088
TTY 614-508-2251 or
877-786-1642

Basic life insurance amount

Payroll/Personnel officer
Your facility

Dental

MetLife
800-984-8649

Vision
EyeMed
866-723-0514

Vision Service Plan (VSP)
800-877-7195

Legal Service Plan

Hyatt Legal Plans, Inc.
800-821-6400

Working Solutions Information and Referral Service

Working Solutions
800-358-8515

Supplemental life insurance

Prudential
800-778-3827