

UNION BENEFITS TRUST  
HOW TO ENROLL IN YOUR BENEFITS  
FOR  
NEW MEMBERS  
ENROLLMENT GUIDE

# benefits



REVISED JUNE 2008





## DEAR MEMBER,

### **Welcome to the Union Benefits Trust!**

As a newly hired employee, you have lots of information to sort through, regarding many of the benefits you will receive or programs for which you are now eligible. To help you through this busy time, we will try to make it simple for you. 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):

- Supplemental life insurance. Now is the only time you can enroll for 3 times your earnings without providing proof of good health, and
- Legal insurance. Established term employees are not eligible for this coverage.

To enroll, complete and mail the enclosed forms within 90 days of your hire date. Before you enroll, please read up on plan details and costs; these benefits are voluntary and are deducted once a month from your pay.

The enclosed plan booklet describes these benefits in full detail, along with the Working Solutions program, in which you are automatically enrolled. This program is a work/life information and referral service, and the Trust pays the cost for you and your family.

Remember you have only 90 days from hire to enroll in supplemental life insurance and the legal plan. If you miss this opportunity, you will have to wait until the next open

enrollment to sign up for coverage, but some of the terms and conditions will be different at that time.

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](http://www.benefitstrust.org).

The Trust will mail you quarterly newsletters (*Trust Talk*) to help you stay current on your benefits, a packet at open enrollment (typically spring every year) to let you know what your enrollment options are and a packet (much like this one) at your one-year anniversary of hire so that you can enroll in dental and vision insurance. We mail all of these materials to your home, so please keep your address current with your Human Resources officer at your worksite. If you think you are missing critical Trust information, do not hesitate to go online or call us; enrollment deadlines, such as the 31 days from your one-year anniversary date, pass quickly.

We look forward to serving you.

***The Board and Staff of the Union Benefits Trust***

# SUPPLEMENTAL LIFE ENROLLMENT FORM

Policyholder's Name: Union Benefits Trust

Group Policy Number: LG-01049

New enrollment       Change       Terminate member coverage (includes spouse/children coverage)

Please mark the appropriate boxes if you are making a change (check all that apply)

Increase My Coverage     Add Spouse Coverage     Add Children Coverage     Change Smoker Status     Change Spouse Smoker Status  
 Decrease My Coverage     Increase Spouse Coverage     Drop Children Coverage     Change to Union-Represented from Exempt  
 Other (Name Change, etc.)     Drop Spouse Coverage

Payroll Number: \_\_\_\_\_ - the State Department in which you work.

Member Insurance Total Amount Requested: \_\_\_\_\_ Include current amount of coverage for the member, plus the amount of increase in \$10,000 increments (do not include spouse/children amounts). The amount for which you apply and which Prudential approves will be the amount you may port when you leave State service.

Member's Name (Last, First, Middle Initial) \_\_\_\_\_

Member's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Social Security No. \_\_\_\_\_ DOB \_\_\_\_\_  M  F     Married  Single

Occupation \_\_\_\_\_ Date Employed \_\_\_\_\_ Base Annual Earnings \_\_\_\_\_

Telephone No. \_\_\_\_\_

Have you smoked cigarettes or used any form of tobacco in the past 12 months?  Yes  No

(The right to change the beneficiary is reserved. To name beneficiaries, please use the spaces on the back of this form.)

Member Must Have Supplemental Life Insurance to Enroll Spouse and/or Children.

You will automatically be the beneficiary for life insurance on the lives of your spouse and children, if surviving; otherwise it will be the estate of the spouse and children, subject to policy provisions.

Spouse Coverage Desired?  Yes  No      Spouse Insurance Total Amount:  \$10,000     \$20,000     \$30,000     \$40,000  
(Include current amount of coverage)

Spouse's Name (Last, First, Middle Initial) \_\_\_\_\_

Spouse's Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_ Date of Marriage \_\_\_\_\_

Has your spouse smoked cigarettes or used any form of tobacco in the past 12 months?  Yes  No

Child(ren) Coverage Desired?  Yes  No    Child(ren) Insurance Amount: \$7,000 per Child    Number of Children \_\_\_\_\_

You have 90 days from your hire date to purchase supplemental life coverage for you, your spouse and your dependent children. Coverage is also available during each Trust-sponsored open enrollment period.

This plan is totally separate from your basic life plan with Union Benefits Trust, and the amount of insurance elected as supplemental does not change your basic life insurance. If a husband and wife are both State employees, they have coverage as either a spouse or a member, but not both. Children can only be covered as dependents of only one member.

I understand that when I leave State service I will be able to port the coverage I have purchased as an active member, and that I will not be able to apply for more coverage. I acknowledge that I have been informed that only member coverage is eligible for port, not dependent spouse or child coverage.

I hereby request group insurance for myself and/or for my dependents and hereby authorize my employer or successor to make deductions from my earnings of the required contributions to apply toward the premiums for the insurance provided for in the policy of group insurance issued to Union Benefits Trust by The Prudential Insurance Company of America.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SUPPLEMENTAL LIFE BENEFICIARY DESIGNATION FORM

Use the space below to name beneficiaries of the member. If you wish, you may name one or more primary beneficiaries. You may also name one or more contingent beneficiaries. This form allows you to name up to two primary and two contingent beneficiaries. If you need additional space, please attach a separate sheet of paper. After you have completed your entries, please sign and date in the space below.

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.

## PRIMARY BENEFICIARY(IES)

First Name	Middle Initial	Last Name	Relationship to member	DOB
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Address	Social Security Number	% Share
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First Name	Middle Initial	Last Name	Relationship to member	DOB
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Address	Social Security Number	% Share
---------	------------------------	---------

## CONTINGENT BENEFICIARY(IES) (optional)

First Name	Middle Initial	Last Name	Relationship to member	DOB
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Address	Social Security Number	% Share
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First Name	Middle Initial	Last Name	Relationship to member	DOB
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Address	Social Security Number	% Share
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The Supplemental Life Coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Contract Series 83500.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

Mail the original form to: The Prudential Insurance Company of America • P.O. Box 5072 • Millville, NJ 08332-9931

Call Prudential with questions: 800-778-3827



# LEGAL PLAN ENROLLMENT FORM

Enrollment       Change Coverage Level       Date of Family Status Change \_\_\_\_\_

Coverage level may only be changed within 31 days of the occurrence of the family status change.

Member Name (First, Middle, Last) \_\_\_\_\_

Social Security Number \_\_\_\_\_

Home Street Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_

Union Name \_\_\_\_\_

Agency Name \_\_\_\_\_

Work Address \_\_\_\_\_

Employee ID Number \_\_\_\_\_

Work Phone \_\_\_\_\_ Alternate Phone Number (not work) \_\_\_\_\_

## LEVEL OF COVERAGE

SINGLE \$13.40 a month

FAMILY \$16.45 a month

I authorize the State of Ohio to take the premium for the legal service plan coverage I select once a month from my pay. Coverage will begin under the plan the first of the month following the first payroll deduction for the legal plan. I understand that my election will remain in force until I change or drop my coverage, and that I may only make changes or drop coverage during open enrollment for the following July 1 coverage effective date; however, changes may be made mid-year due to a qualified family status change. My coverage will also end if I am no longer an eligible Trust member or I leave State employment once payroll deductions stop.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

AFTER SIGNING AND DATING THE FORM, MAIL IT TO HYATT NO LATER THAN 90 DAYS FROM DATE OF HIRE.

Please make a copy of this form before mailing the original to:

Hyatt Legal Plans • Eaton Center • 1111 Superior Avenue • Suite 800 • Cleveland, Ohio 44114-2507

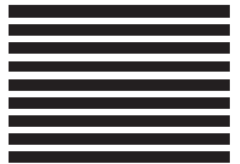
Group legal service plans are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio.

To mail, fold this end down first.

FOLD HERE



NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES



**BUSINESS REPLY MAIL**  
FIRST-CLASS MAIL PERMIT NO. 5388 CLEVELAND, OH

POSTAGE WILL BE PAID BY ADDRESSEE

**Hyatt Legal Plans, Inc.**  
**Attention: Director of Administration**  
**1111 Superior Ave. E., Suite 800**  
**Cleveland, OH 44114-9584**



FOLD HERE

Second, fold this end up, and place tape on edge, in center.  
Bottom fold should be smooth and not taped.



## **DEADLINE REMINDERS**

- No later than 90 days from hire!!!
- Mail your enrollment form for Legal to Hyatt. The form in this book is postage paid!
- Mail your enrollment form for supplemental life insurance to Prudential.
- Supplemental life insurance and/or the legal service plan may be elected only at hire or during open enrollment.
- Established term employees should check with their Human Resources officers to determine enrollment and eligibility information.

## **WHAT COMES NEXT**

Dental, vision and basic life insurance have a waiting period. When your one-year anniversary of continuous service as a Union-

represented State employee approaches, the Trust will mail you an anniversary highlights packet that you will need to enroll. Read the anniversary materials carefully and keep them for future reference. Remember, if your one-year anniversary date approaches and you don't have your materials, contact us immediately!

## **HOW TO ENROLL IN DENTAL AND VISION COVERAGE**

To enroll in these plans, complete the Enrollment and Change form (that will be included in your anniversary enrollment guide). Indicate the eligible dependents you wish to cover, and return the form to your Human Resources officer. If you enroll within 31 days of your anniversary, your coverage will begin on the first of the month following your anniversary date. If you don't enroll within 31 days

of your anniversary, you'll have to wait until the next Trust open enrollment for dental or vision coverage. To make sure your coverage begins on time, complete the form and give it to your Human Resources officer as soon as possible.

## **PAPERWORK FOR YOUR BASIC LIFE AND AD&D COVERAGE**

You automatically receive this free coverage the first of the month following your one-year anniversary date. Please complete a beneficiary designation form (also in your anniversary enrollment guide). Mail it to Prudential once it's complete (after making a copy for your records). Don't let this benefit be delayed in reaching your family when they may need the money most.

## 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](http://www.benefitstrust.org)

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

Benefits Trust

614-508-2255 or 800-228-5088

### *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

## SAVE FOR YOUR ONE YEAR ANNIVERSARY

*Basic life insurance questions*

Human Resources officer  
Your facility

Benefits Trust customer service

### *Dental*

MetLife  
800-984-8649

### *Vision*

EyeMed  
866-723-0514

### *Vision Service Plan (VSP)*

800-877-7195

