IBEW 125 - PGE
HEALTH & WELFARE TRUST

2026 BENEFITS OPEN ENROLLMENT AND DEPENDENT ADD/REMOVE FORM

LONG-TERM DISABILITY RECIPIENTS RECEIVING MEDICARE (ELIGIBLE FOR MEDICAL MEDICARE SUPPLEMENT PLAN AND ACTIVE DENTAL AND VISION PLANS)

Complete this form to elect the medical Medicare Supplement Plan, and Active Dental and Vision (bundled) Plan and to add or remove dependents from your coverage. **Open enrollment is November 3 – November 17, 2025**. Return your completed form by **5 PM Pacific Time on November 15 to:**

BeneSys, Inc.
IBEW 125 - PGE Health and Welfare Trust
PMB 116, 5331 S Macadam Ave, Suite 258
Portland, OR 97239-3871

Phone (503) 224-5906
Toll Free (877) 545-9471
E-Fax (781) 398-9219

Section 1 – Member Information		
Participant's Full Name		**SSN**
Address		**City**
State	**Zip**	**Date of Birth**
Home Phone		**Mobile Phone**

Section 2 – Health Plan Elections (Medical, Dental and Vision)	
CHOOSE YOUR COVERAGE	**Medicare Supplement Plan**
	Elect Medical, Dental and Vision Coverage
Medical, dental and vision benefits are offered together in one package. You must have medical coverage in order to elect dental and vision coverage. The Trust doesn't allow standalone dental and vision coverage. Refer to the enclosed rate sheet for your required monthly cost share amount.	☐ $134.55

Section 3 – Dependent Information

Complete this section only if you want to add a new dependent or drop a dependent from your coverage. Dependents include your spouse or domestic partner, child up to age 26 or disabled child of any age who is dependent upon you for support.

Please note: You must attach the appropriate legal documentation that applies to your dependents. Please refer to the enclosed Eligibility Documentation Policy/Proof of Dependent Eligibility Documents form. If you have any questions, please call the Trust Fund Office at (503) 224-5906 or (877) 545-9471.

Action	Full Name	Relationship To You	Birth Date	SSN	Gender
☐ Add ☐ Drop					☐ M ☐ F
☐ Add ☐ Drop					☐ M ☐ F
☐ Add ☐ Drop					☐ M ☐ F
☐ Add ☐ Drop					☐ M ☐ F

Are any of your dependents currently receiving Medicare or planning to receive Medicare in 2026? You are required to provide a copy of your dependent's Medicare card to the Trust Office when your dependent becomes eligible for Medicare.	☐ Yes	☐ No

Section 4 – Member's Certification and Authorization

By signing below, I agree to all of the following statements:

(a) I will notify the Trust Office within 31 days of any changes to the above enrollment and plan selection information.

(b) All of the information I provided on this form is complete and correct. I understand that stating false or misleading information, or omitting material information, is grounds for denial of benefits.

It is a crime under the Employee Retirement Income Security Act to knowingly provide false, incomplete or misleading information to a health plan for the purpose of defrauding the health plan. Possible penalties include imprisonment, fines, denial of benefits and restitution to the Plan for both Plan benefit payments and the monetary value of the medical coverage.

I agree to pay the required monthly cost share amount applicable for my eligibility status and the coverage options I have elected.

Member's Signature _____ **Date** _____