IBEW 125 - PGE
HEALTH & WELFARE TRUST

2026 BENEFITS OPEN ENROLLMENT AND DEPENDENT ADD/REMOVE FORM

COBRA PARTICIPANTS AND DIVORCED SPOUSES AGE 55 AND OLDER
(ELIGIBLE FOR ACTIVE PLAN)

Complete this form to change or waive a medical, 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 17 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

You may elect to have Medical Only or Medical, Dental and Vision. Dental and vision benefits are optional and offered together in one package. You must elect medical coverage in order to elect dental and vision coverage. The Trust doesn't allow standalone dental and vision coverage. If you opt out of dental and vision coverage, you won't be able to re-enroll in the future.

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

Section 2 – Medical Plan Election

MEDICAL PLAN	HSA Qualified Plan*	PPO Plan
CHOOSE ONE MEDICAL PLAN You must elect medical coverage in order to elect dental and vision coverage. The Trust doesn't allow standalone dental and vision coverage See the enclosed rate sheet for your required monthly premium amount. If you opt out of medical coverage, you won't be able to re-enroll in the future.	☐	☐
	Waive Medical Coverage	
	☐	

CHOOSE OR WAIVE DENTAL AND VISION COVERAGE	Elect Dental and Vision Coverage	Waive Dental and Vision Coverage
Dental and vision benefits are optional and offered together in one package. If you opt out of dental and vision coverage, you won't be able to re-enroll in the future. **You must elect medical coverage in order to elect dental and vision coverage. The Trust doesn't allow standalone dental and vision coverage.** See the enclosed rate sheet for your required monthly premium amount.	☐	☐

*If you elect the HSA Qualified Plan, you may choose to contribute to your HSA (see Section 4).

Section 3 – Dependent Information (applies to COBRA participants only)

Complete this section only if you are a COBRA participant and 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 Documentation Form. If you have questions, call the Trust 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 you or any dependents receiving Medicare or planning to receive Medicare in 2026? You must stop contributing to your HSA at least six months before you enroll in Medicare. When you enroll in Medicare Part A, you'll receive up to six months of retroactive coverage. If you don't stop HSA contributions at least six months before Medicare enrollment, you may incur a tax penalty on those contributions.	☐ Yes	☐ No

Section 4 – Health Savings Account (HSA) Contribution

2026 IRS Contribution Limits for HSA

☐ **Individual coverage**: IRS maximum is $4,400.

☐ **Family coverage**: IRS maximum is $8,750.

Catch-up contribution: If you are the account holder and age 55 or older in the 2026 calendar year, you can contribute an additional **$1,000** per year to your HSA.

Your HSA Contribution Election for 2026

SELECT ONE:	☐ Yes, I would like to open and contribute to my HSA. If this is your first year electing an HSA, HealthEquity will send you a Welcome Kit with details on how to make contributions. You may change your HSA contribution election at any time.	☐ No, I do not want to open an HSA.

Section 5 – 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.

(c) If I elected the HSA Qualified Plan: I received and reviewed the HSA rules and regulations contained in the *2026 Open Enrollment Guide*. I confirm that I meet the HSA eligibility requirements. Further, I had time to review and ask all of the questions I had about participating in the HSA Qualified Plan before enrolling. Finally, I know that my election is binding until the next open enrollment period (except for certain life events).

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 premium amount applicable for my eligibility status and the coverage options I have elected.

Member's Signature _____ **Date** _____