IBEW 125 - PGE
HEALTH & WELFARE TRUST

2026 BENEFITS OPEN ENROLLMENT AND DEPENDENT ADD/REMOVE FORM

RETIREES AGE 65 OR OLDER WITHOUT DEPENDENTS UNDER AGE 65 (ELIGIBLE FOR THE MEDICARE RETIREE PLAN – UHC MEDICARE EXCHANGE)

Complete this form to elect or waive dental and vision (bundled) coverage and to add or remove dependents from your coverage. You must be enrolled in an UHC Medicare Exchange Plan to be eligible to enroll in the dental and vision plan. **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

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

Section 2 – Dental and Vision Election		
CHOOSE OR WAIVE DENTAL AND VISION COVERAGE FOR YOU AND YOUR DEPENDENT(S)	**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 for yourself and your dependents, you won't be able to re-enroll in the future (certain exceptions may apply; contact the Trust office for details). See the enclosed rate sheets for your required monthly premium amount. You must be enrolled in a UHC Medical plan.	☐	☐

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.

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

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

Member's Signature _____ **Date** _____