



**IBEW 125 - PGE  
HEALTH & WELFARE TRUST**



**2026 BENEFITS OPEN ENROLLMENT AND DEPENDENT ADD/REMOVE FORM**

LONG-TERM DISABILITY RECIPIENTS NOT RECEIVING MEDICARE (ELIGIBLE FOR ACTIVE PLAN)

Complete this form to change your medical 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

<b>Section 1 – Member Information</b>		
<b>Employee's Full Name</b>		<b>SSN</b>
<b>Address</b>		<b>City</b>
<b>State</b>	<b>Zip</b>	<b>Date of Birth</b>
<b>Home Phone</b>		<b>Mobile Phone</b>
<b>Section 2 – Medical Plan Election</b>		
<b>MEDICAL PLAN</b>		<b>HSA Qualified Plan*</b>
<b>CHOOSE ONE MEDICAL PLAN</b> (the amount shown is your <b>monthly</b> cost share for medical, dental and vision coverage combined; dental and vision benefits are automatically provided regardless of your medical election).		<input type="checkbox"/> \$13.91 per month <input type="checkbox"/> \$202.00 per month
* If you enroll in the HSA Qualified Plan, there is no medical cost share required (you only pay the cost share for dental and vision benefits). Also, you may choose to contribute to your HSA (see Section 4).		



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### 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 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
<input type="checkbox"/> Add <input type="checkbox"/> Drop					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add <input type="checkbox"/> Drop					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add <input type="checkbox"/> Drop					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add <input type="checkbox"/> Drop					<input type="checkbox"/> M <input type="checkbox"/> F
you or any dependents receiving Medicare or planning to receive Medicare in 2026?					<input type="checkbox"/> Yes <input type="checkbox"/> No
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.					

### 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, the account holder, are 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

<b>SELECT ONE:</b>	<input type="checkbox"/> 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.	<input type="checkbox"/> No, I do not want to open an HSA.
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### 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 cost share amount applicable for my eligibility status and the coverage options I have elected.

**Member’s Signature** \_\_\_\_\_ **Date** \_\_\_\_\_