Employees Club of California

Premium Calculations

Benefit Amount				
$10,000	=	Monthly rate	+	Wellness rate
$20,000	=	Monthly x 2	+	Wellness rate
$30,000	=	Monthly x 3	+	Wellness rate
$40,000	=	Monthly x 4	+	Wellness rate
$50,000	=	Monthly x 5	+	Wellness rate

Individual

Age	Base Plan	Premier Plan
18-24	$ 3.55	$ 3.99
25-29	4.18	4.83
30-34	6.07	7.26
35-39	8.17	10.03
40-44	12.13	15.30
45-49	16.29	21.23
50-54	22.73	31.09
55-59	29.77	43.31
60-64	42.60	67.23
65-69	51.39	89.98
Wellness:	$ 2.17	$ 2.17

Single Parent

Age	Base Plan	Premier Plan
18-24	$ 5.07	$ 5.63
25-29	5.70	6.48
30-34	7.58	8.91
35-39	9.69	11.68
40-44	13.65	16.94
45-49	17.81	22.88
50-54	24.25	32.74
55-59	31.29	44.96
60-64	44.09	68.90
65-69	52.91	91.65
Wellness:	$ 2.38	$ 2.38

Family

Age	Base Plan	Premier Plan
18-24	$ 8.62	$ 9.62
25-29	9.86	11.31
30-34	13.65	16.16
35-39	17.83	21.71
40-44	25.76	32.24
45-49	34.10	44.11
50-54	46.97	63.85
55-59	61.06	88.27
60-64	86.69	136.13
65-69	104.28	181.64
Wellness:	$ 3.25	$ 3.25

This is not a full disclosure of plan qualifications and limitations. Specific limitations and exclusions can be found in the Regulatory and Technical Information guide for this product on disclosure.manhattanlife.com. Please review this information before applying for coverage. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made. This policy provides limited benefits. ManhattanLife Critical Illness/Cancer Policy is form 8011CA. Underwritten by ManhattanLife Assurance Company of America.

The Employees Club of California is a membership program of LACEA Insurance Services, Inc. (CA DOI Lic. #0B98000). LACEA Insurance Services, Inc. is a licensed insurance agency offering insurance benefits to qualified Club members. LACEA Insurance Services, Inc. is not directly affiliated with ManhattanLife Assurance Company of America.

ECC-ManhattanLife 0122

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EMPLOYEES CLUB OF CALIFORNIA
311 S SPRING ST STE 1300
LOS ANGELES CA 90013-9844

Critical Illness & Cancer Insurance

EMPLOYEES CLUB OF CALIFORNIA
www.EmployeesClub.com

The expenses associated with a critical illness can be overwhelming to you and your family, even when you have health benefits. This plan can assist you with those expenses, so you can focus on getting better. ManhattanLife Critical Illness and Cancer Plan provides a cash payment directly to you after diagnosis, in addition to any other benefits. You may use this benefit for any purpose.

Questions?

Club Counselors are ready to answer your questions about ManhattanLife Income Protector short term disability insurance. Call today.

(800) 464-0452

Employees Club of California
311 S. Spring St. Ste 1300
Los Angeles, CA 90013
www.EmployeesClub.com

Why do I need Critical Illness & Cancer insurance?

Consider this:

In the United States…

- Every 43 seconds someone suffers a heart attack [1]
- More than 1.6 million new cancer cases are expected to be diagnosed in 2016 [2]

Indirect and out-of-pocket costs you may incur:

Medical insurance shortfalls

- Deductibles and copayments
- Doctors, hospitals, cancer centers outside managed care program
- Treatments considered experimental

Loss of assets

- Depleted savings
- Personal property

Other indirect costs

- Home healthcare
- Transportation expenses to and from doctors and treatment facilities
- Food and lodging if treatment is out of town
- Child care

Normal living expenses

- Mortgage payments or rent
- Car payments
- Utility bills
- Groceries and household items
- Credit card payments

[1] *Heart Disease and Stroke Statistics — 2015 Update: a report from the American Heart Association. Circ. 2015;131;e29-e322*

[2] *American Cancer Society, Cancer Facts & Figures 2016*

Here's how it works:

- When you or a member of your family are diagnosed with a covered critical illness, such as a heart attack, stroke or cancer
- File a claim for your critical illness and cancer benefit
- You are eligible to receive a benefit in each of the categories
- Receive a check for the covered amount to be used however you want

The plan

- Pays one lump sum benefit per category directly to you or whomever you designate
- Can cover you, your spouse and your children
- Can be used to pay for unexpected expenses like your medical deductible, home healthcare, rehabilitation expenses or day-to-day living expenses
- Coverage levels: $10,000 - $50,000
- $50 health screening benefit for each covered member on the policy
- $50 mammography screening benefit included for covered member (refer to schedule)

Plan features

- Benefit choices: $10,000, $20,000, $30,000, $40,000 or $50,000

Plan types

- Individual (adult member)
- Family (two parents and all children)
- Single parent (parent and all children)

Issue age premiums

- Premiums do not increase with advancing age

Renewable

- Policy is renewable as long as you are an active member of the association

Easy to apply

- No medical exam, no physician statements, no telephone interview — just complete an application

Critical Illness and Cancer Plan Benefits

Premier coverage pays a 100 percent benefit per category.

Reduction	Benefit does not reduce due to age.
Vascular conditions	• Heart attack • Transplant as a result of heart failure • Stroke • Coronary artery bypass surgery as a result of coronary artery disease
Cancer conditions	• First diagnosis of internal cancer or malignant melanoma • Carcinoma in situ
Other critical illnesses	• Transplant, other than heart • End-stage renal failure • Coma • Severe burns • Permanent paralysis due to an accident

Additional benefits

Waiver of premium	Waiver of premium for disability: If the member becomes totally disabled for at least 180 days, his/her premiums will be waived. For members ages 18 - 55.
Health screening	Benefit pays $50 per calendar year for a covered health screening. There are 18 covered tests including colonoscopies, Pap and stress tests.
Mammography screening	$50 mammography screening benefit included for covered member as follows: 1) a baseline mammogram for women ages 35 - 39, inclusive, 2) one mammogram every two years for women ages 40 - 49, or more frequently based on a physician's recommendation, 3) one mammogram every year for women ages 50 and older.
Benefit recurrence	Provides an additional benefit for the same condition if a covered participant is treatment-free for at least 12 months.

Base plan option

The base plan includes the above benefits **except:**

- The Recurrence Benefit is NOT available under the Base Plan.
- The Base Plan Benefit will be reduced 50 percent at age 70.

California

Voluntary Group Critical Illness Enrollment Form

ManhattanLife. Standing By You. Since 1850.

PLEASE INDICATE: ☐ ENROLLMENT FOR NEW COVERAGE ☐ CHANGE TO EXISTING COVERAGE

Proposed Insured (Please Print)

Person Proposed for Coverage (First Name, MI, Last Name) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ☐ Male ☐ Female

Address (Street or R.R.)

City | State | Zip Code | Home Telephone ( ) -

Employer Name or Group Number

L A C E A (Los Angeles City Employees Association)

Date of Employment (MM/DD/YYYY) / /

How many hours per week do you work? | Employee Class (If Applicable) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Spouse

Spouse or Domestic Partner Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ☐ Male ☐ Female

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ☐ Male ☐ Female

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ☐ Male ☐ Female

Child Three

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ☐ Male ☐ Female

CRITICAL ILLNESS INSURANCE

● Employee ☐ Spouse or Domestic Partner ☐ Child(ren)

	Employee	Spouse
Has any Proposed Insured used any form of tobacco in the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No

Base Plan ● Vascular ● Cancer ● Other Critical Illnesses

Base Benefit Benefit Amount $, Total Modal Premium $.

Optional Benefits ● Health Screening ☐ Automatic Benefit Increase ☐ **Benefit Recurrence** (Premier Plan)

Underwritten by ManhattanLife Assurance Company of America

SECTION I: Complete this Section if applying for Guarantee Issue.

	EMPLOYEE		SPOUSE		CHILD 1		CHILD 2		CHILD 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you Actively at work? **Actively at work** means you are performing your normal duties on a full-time basis and paid regular earnings at your Employer's usual place of business or at a location to which the Employer's business requires you to travel.	☐	☐								
2. A) Will this coverage replace a critical Illness policy or certificate of Insurance paid for, by, or through your employer?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B) Is the Proposed Insured covered by an individual or group insurance policy that provides medical, hospital and surgical coverage? *Persons without comprehensive medical coverage are not eligible for this coverage.*	☐	☐								

SECTION II: Complete this Section and Section I if applying for Contingent Guarantee Issue.

	EMPLOYEE		SPOUSE		CHILD 1		CHILD 2		CHILD 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3. Has the Proposed Insured been performing their normal duties at work, home, or school on a full-time basis and not having missed more than 5 consecutive days In the last 12 months due to illness or Injury, except for normal pregnancy?	☐	☐								
4. Is any Proposed Insured now being treated, or ever been treated or diagnosed, by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. In the 6 months prior to the application date, has any Proposed Insured been hospitalized as an inpatient or outpatient, or missed more than 5 consecutive days of work due to an illness or Injury, except for normal pregnancy?	☐	☐								

SECTION III: Complete this Section, Section I and Section II if applying for Simplified Issue. In questions 6 and 7, complete items A, B, and/or C as appropriate.

	EMPLOYEE		SPOUSE		CHILD 1		CHILD 2		CHILD 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
6. Within the past 5 years, has any Proposed Insured been diagnosed with or treated for:										
A) **Vascular:** Heart disease, including angina; heart attack; congestive heart failure; heart bypass; cerebrovascular disease, Including Transient Ischemic Attack (TIA); stroke (blockages or hemmorhage); diabetes; or blood pressure readings above the normal range which have not been controlled with medication?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B) **Cancer:** Cancer, including melanoma; leukemia; malignant tumors; or skin cancers?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C) **Other:** Drug abuse or alcohol abuse; disease of the liver, kidney or digestive system; disease or disorder of the lung; diabetes; or diseases of the nervous system, including Parkinson's, MS and cerebral palsy?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. To the best of your knowledge and belief, have any 2 of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:										
A) **Vascular:** Heart attack, heart disease or stroke?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
B) **Cancer:** Cancer?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
C) **Other:** Kidney disease or diabetes?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. A) Proposed Insured — HEIGHT (ft - in) ☐ - ☐☐ — WEIGHT (lbs) ☐☐☐

B) Spouse or Domestic Partner — HEIGHT (ft - in) ☐ - ☐☐ — WEIGHT (lbs) ☐☐☐

C) Child One — HEIGHT (ft - in) ☐ - ☐☐ — WEIGHT (lbs) ☐☐☐

D) Child Two — HEIGHT (ft - in) ☐ - ☐☐ — WEIGHT (lbs) ☐☐☐

E) Child Three — HEIGHT (ft - in) ☐ - ☐☐ — WEIGHT (lbs) ☐☐☐

EMPLOYEE'S REPRESENTATION AND AGREEMENT

Any person who knowingly and with intent to injure, defraud or decieve any insurer files a statement of claim or an Application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement to prison.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that the above statements are representations and not warranties.

Signed At _____ _____
City State

_____ / / _____
Signature of Proposed Insured/Owner Date (MM/DD/YYYY)

INSURANCE PRODUCER'S USE

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

_____ / / _____
Signature of Licensed Insurance Producer (Not required) Date (MM/DD/YYYY)

Insurance Producer Number	% Credit	Insurance Producer Number	% Credit

FOR LOS ANGELES CITY AND DWP EMPLOYEES

PAYROLL DEDUCTION AUTHORIZATION

By signing the Payroll Authorization Form, I authorize a monthly payroll or pension deduction of $7.50 ($4.00 for retirees), in addition to any other authorized deductions, for access to full Club benefits. This authorization will remain in effect until I revoke it in writing.

Last Name | First Name | Middle Initial | Social Security Number ___ - ___ - ____

◯ City Dept # | ◯ City Employee # (5 - 6 Digits) | ◯ DWP Employee #

Please select one:

- ◯ City Active
- ◯ City Retired
- ◯ DWP Active
- ◯ DWP Retired
- ◯ Fire/ Police Pension (Officers Only)

To: **Controller–City of Los Angeles, or Fire and Police Pension, or City Employees Retirement System, or Paymaster–Department of Water and Power**

I hereby authorize the deduction from my salary or pension of amounts sufficient to cover premiums/membership fees for any of my group benefits provided by the Employees Club of California. In the event that any premiums should change due to age, an increase in salary or benefits, or a general rate increase for the entire Association, I authorize you to make such changes upon notification from the Employees Club of California. This deduction will remain in force until canceled by me in writing.

Employees Club of California
311 S. Spring St. STE 1300
Los Angeles, CA 90013
(800) 464-0452
info@employeesclub.com
www.EmployeesClub.com

SIGN HERE X

Los Angeles City / DWP Employee | Date

FOR OFFICE USE ONLY

Code | Deduction

FOR EMPLOYEES OF THE STATE OF CALIFORNIA

PAYROLL DEDUCTION AUTHORIZATION

By signing the Payroll Deduction Authorization, I authorize a monthly deduction of $7.50 from my payroll, plus any other authorized deductions, for full Club benefits access. This remains in effect until I revoke it in writing.

Last Name	First Name	Middle Initial	Social Security Number
			– –

Organization Name

Los Angeles City Employees Association, Inc. (LACEA)

Ded./ Org. Code: 089-067

To: **California State Controller**

I hereby authorize the State Controller to deduct from my salary and wages the amount specified now or in the future for membership dues and any benefit program for which I have applied, which is sponsored by the above-named organization. This authorization will remain in effect until canceled by me or by the above-named organization. I certify that I am a member of the above-named organization and understand that termination of membership will cancel all deductions made under this authorization.

SIGN HERE X

California State Employee Date

Employees Club of California
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info@employeesclub.com
www.EmployeesClub.com

FOR OFFICE USE ONLY

Code	Deduction