MIB Disclosure Notice (retain for your records)

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company ("MetLife") or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of the request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. MetLife, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Brought to you by:

Employees Club of California

311 South Spring Street, Suite 1300
Los Angeles, CA 90013

(800) 464-0452

www.EmployeesClub.com

This plan is available in CA only.
Policy Number 165584-1-G

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact your plan administrator for costs and complete details.

Underwritten by:

MetLife

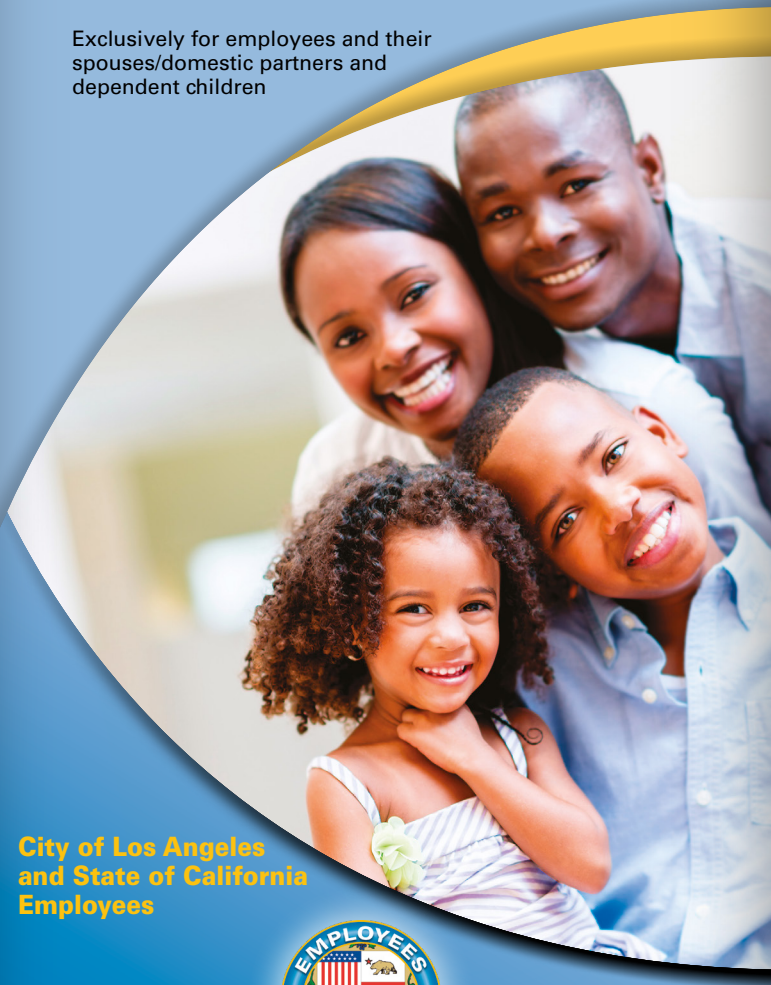
Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com

L0723033890[exp0725][CA]

Group Term Life Insurance and Accidental Death and Dismemberment Insurance

Apply for up to $500,000 of Term Life Insurance and AD&D Insurance

Exclusively for employees and their spouses/domestic partners and dependent children



City of Los Angeles and State of California Employees

EMPLOYEES CLUB OF CALIFORNIA

www.EmployeesClub.com

Coverage That Fits Your Needs — Premiums That Fit Your Budget

Convenience – No need to keep track of another monthly bill; premiums are deducted from your paycheck.

Multiple coverage levels – Select the plan that works best for your family's needs.

Portable coverage – Keep 50% of your coverage even if you change jobs or retire.

Spouse/domestic partner coverage – Your spouse or domestic partner is also eligible to apply for his or her policy at the same economical group rates.

Coverage for dependent children – Special rates are available for eligible dependents.

Premium refunds – Life insurance premiums left over after group claims and expenses are paid are divided up and given back to policyholders.

Easy application – Application is simple to complete.

No-pressure professionals – The Club is a service of the Los Angeles City Employees Association, Inc., a not-for-profit organization, and our insurance counselors aren't on commission. They won't try to sell you something you don't need; their goal is to make sure you get the coverage that's right for you and your family.

The Club's Life Insurance is backed by the power of Metropolitan Life Insurance Company (MetLife). MetLife is one of America's most respected insurance companies.

If you have any questions call 1-800-464-0452, Option 4.

Employees Club of California

311 South Spring Street, Suite 1300
Los Angeles, CA 90013

Eligibility Requirements for Life Insurance

You are eligible to apply for this coverage if you are an active member of Los Angeles City Employees Association in good standing; a full time employee working 30 hours per week for the City of Los Angeles, the Department of Water and Power, the State of California or any of its political and administrative divisions and subdivisions thereof, or any agency or instrumentality of the State of California. If you apply, your lawful spouse/domestic partner* may also apply for this coverage. If you apply, you may also insure your dependent children under age 26. Children 15 days but less than 6 months are eligible for $2,500 of life insurance. Children six months or more are eligible for $25,000 of life insurance (subject to state variations).

Effective Date for Life Insurance

You and your spouse, if applying, will be insured on the first of the month coinciding with or next following the date MetLife approves the request, provided the required premium is paid. You must be actively at work on the date the insurance is to take effect. If you are not, the insurance will take effect on the day you return to work. Your spouse, if applying, must be able to perform the normal activities of a person of like age and sex, in good health, on the date insurance is to take effect. If not, such insurance will take effect on the day your spouse resumes such activities. Your dependent must not be hospitalized; confined at home under a Physician's care; or receiving or applying to receive disability benefits from any source on the date their insurance takes effect. If so, their insurance will take effect on the day after they are discharged.

Date Insurance Ends for Life Insurance

As long as you continue to pay premiums, the group policy remains in effect, you continue to be a member in an eligible class and insurance does not end for your class, your coverage will not end. If you retire, coverage under this plan will end, and at which time you are eligible for Retiree Life coverage. In addition, a dependent's insurance will end when they are no longer a dependent. With respect to spouses, as long as marriage does not end by divorce or annulment, coverage will continue. With respect to domestic partners, as long as the person remains the domestic partner of the member, coverage will continue.

Exclusions for Life Insurance

If you commit suicide within 2 years from the date Life Insurance takes effect, we will not pay such insurance and our liability will be limited as follows: Any premium paid by you will be returned to the beneficiary and any premium paid by the policyholder will be returned to the policyholder. **

Eligibility Requirements for AD&D Insurance

You are eligible to apply if you are an active member of Los Angeles City Employees Association in good standing; a full time employee working 30 hours per week for the City of Los Angeles, the Department of Water and Power, the State of California or any of its political and administrative divisions and subdivisions thereof, or any agency or instrumentality of the State of California.

Effective Date for AD&D Insurance

You will be insured for Accidental Death and Dismemberment on the date stated in writing by Metropolitan Life, provided the required premium is paid. You must be actively at work on the date your insurance is to take effect. If you are not, insurance will take effect on the day you resume such work.

Date Insurance Ends for AD&D Insurance

As long as you remain a member in good standing, continue to pay premiums, the group policy remains in effect, and insurance does not end for your class, your coverage will not end. In addition, with respect to spouses, as long as marriage does not end by divorce or annulment, coverage will continue. With respect to domestic partners, as long as the person remains the domestic partner of the member, coverage will continue.

Exclusions for AD&D Insurance

No benefits will be paid for any loss caused or contributed to by: Suicide or attempted suicide; intentionally self-inflicted injury; a physical or mental illness or infirmity, or the diagnosis or treatment of such; infection, other than infection occurring in an external accidental wound; service in the armed forces of any country or international authority; voluntary intake or use by any means of any drug, medication or sedative unless taken as prescribed by a physician or an "over the counter" drug, medication, or sedative taken as directed; alcohol in combination with any drug, medication or sedative; or poison, gas, or fumes; or committing or attempting to commit a felony; War, declared or undeclared; or act of war, insurrection, rebellion or riot. We will not pay benefits for any loss if the injured party is intoxicated at time of the incident and is the operator of a vehicle or other device involved in the incident.

** References to spouse will read domestic partner as it applies, unless specifically stated otherwise.*
*** Exclusions and Variations may vary by state. Please contact your Plan Administrator for more details.*

Group Coverage Exclusively for Club Members

As an active Employees Club of California member in good standing, you are eligible to apply for two insurance plans to help protect your family.

Term Life Insurance

Have you considered how your family will manage financially if they could no longer rely on your income? 80% of consumers say buying life insurance is a relevant financial planning topic for their household. 44% of Millennials overestimate the cost of term life insurance by 5x.[1] If you haven't helped protect your family with life insurance yet, it's time to discover how economical it can be. Additionally, if you are covered by another policy, you owe it to your loved ones to take a moment and explore what you may be missing!

Choose your coverage amount.

Employees (and their spouses/domestic partners) up to age 59, are eligible to apply using the attached One-Step Express application process. Just answer 6 easy medical questions. This may be the fastest, easiest way to get Life Insurance.

Age	Coverage Amount
<40	up to $250,000
40-49	up to $150,000
50-59	up to $100,000
60+	Not available

**Higher coverage amounts are available with full underwriting which requires a Long Application Form.*

All eligible members can apply for up to $500,000 of life coverage by requesting a full underwriting form at 1-800-464-0452, Option 4. That's up to a $500,000 cash benefit delivered to your beneficiaries to cover funeral costs, mortgage payments and other expenses.

Take advantage of group rates for your spouse or domestic partner.

Your spouse or domestic partner can also apply for up to the same amount of coverage for which you apply.

Cover your dependent children.

If you apply for $30,000 of term life coverage, you have the option of adding $25,000 in coverage for each of your eligible dependent children (under age 26) for only $3.00 bi-weekly.* The amount of your dependent coverage cannot exceed your coverage amount.

** Children age 15 days to less than 6 months are eligible for $2,500 of coverage (subject to state variations). Children 0 to 14 days are not eligible.*

Take your coverage with you

Your group term life coverage isn't tied to your current job; you can take 50% of your coverage with you even if you retire, or leave your employment with the City of Los Angeles or the State of California.

Economical Group Term Life Rates

Cost Per $10,000 of Coverage	
Applicant Age	Bi-weekly Rate
Under 30	$ .55
30-34	$ .60
35-39	$ .75
40-44	$ 1.05
45-49	$ 1.55
50-54	$ 2.55
55-59	$ 4.30
60-64	$ 6.15
65-69	$ 12.50
70+**	$ 17.50

Dependent coverage costs $3.00, bi-weekly.

** For renewal purposes only. Coverage amounts for members and spouses/domestic partners, if applying, are reduced to $10,000 upon attainment of age 85.

Potential Premium Refunds

Any unearned life insurance premiums left over after group claims and expenses are paid each year may be divided up and given back to policyholders. Spouses/domestic partners may also be eligible for potential premium refunds.

[1] https://www.bestliferates.org/life-insurance-statistics
[2] verywellhealth.com; accessed 8-19-2021

Accidental Death and Dismemberment Insurance

Accidents are the leading cause of death.[2] Accidental Death and Dismemberment (AD&D) Insurance can help provide additional protection to you and your family should you suffer an injury or lose your life as the result of a covered accident.

Choose your coverage amount.

Eligible members can apply for $25,000 to $500,000 of AD&D coverage for only $0.63 bi-weekly per $25,000 of coverage.

Cover your family at group rates.

Your spouse/domestic partner and dependent children may also apply. The amount of their insurance will be based on a percentage of the amount you have selected. Family Plan covers the Spouse for 50% and Children for 20%. Spouse only would be 60% coverage. Children without a spouse is 25%. Get the Family Plan for only $1.00 bi-weekly per $25,000 of coverage.

Quick And Easy Application Process

As an Employees Club of California member, you are eligible to apply for both policies at economical group rates. Members up to age 59 can complete and mail the enclosed Life Insurance application to: Employees Club of California, 311 S. Spring St., Suite 1300, Los Angeles, CA 90013. For members age 60 and over, please call 1-800-464-0452, Option 4 and request a full application form.

Send No Money Now

Once your application is approved, premiums will be automatically deducted from your paycheck.

30-Day Free Look

Enrollees have 30 days from the date of receipt to examine the Certificate of Insurance and, if unsatisfied for any reason, return it for a full refund of any premiums and fees paid.

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer	Group Customer #	Coverage Effective Date (MM/DD/YYYY)
Los Angeles City Employees Association Inc	**165584**	

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	

☐ New Enrollment ☐ Change in Enrollment	Are you a member of the Association? ☐ Yes ☐ No	Date of Hire (MM/DD/YYYY)

Work Phone #	Cell Phone #	Email Address

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

▶ If you are enrolling in Supplemental/Optional Life or Dependent Spouse/Domestic Partner Life Insurance, you must complete the Health Information section of this form and the enclosed Authorization form for all amounts you are requesting.

Term Life Insurance

☐ Term Life[1]

Enter a multiple of $10,000 up to a maximum of $500,000. $ _____

☐ Dependent Spouse/Domestic Partner[2] Life[1,3]

Enter a multiple of $10,000 up to a maximum of $500,000. $ _____

☐ Dependent Child Life[3]

Accidental Death & Dismemberment (AD&D) Insurance

☐ Voluntary AD&D

First select your option

☐ Member Only ☐ Member + Spouse/Domestic Partner[2]

☐ Member + Child(ren) ☐ Member + Spouse/Domestic Partner[2] + Child(ren)

Then select your level of coverage

Enter a multiple of $25,000 up to a maximum of $500,000. $ _____

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last)	Social Security Number	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)		Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)		Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[2] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner if you and your Domestic Partner have either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to such relationship.

[3] Amounts will be subject to state limits, if applicable.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
ADM *applies to residents of Connecticut, North Dakota and Utah)*

HEALTH INFORMATION

SECTION 1

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. For questions 5 through 12t, for "yes" answers, please provide full details in Section 2.

	Member	Spouse/ Domestic Partner
1. Member's height _____ feet _____ inches Spouse/Domestic Partner height _____ feet _____ inches Member's weight _____ pounds Spouse/Domestic Partner weight _____ pounds		
2. Are you now on a diet prescribed by a physician or other health care provider?	☐ Yes ☐ No	☐ Yes ☐ No
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐ Yes ☐ No	☐ Yes ☐ No
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) Member: _____ Spouse/Domestic Partner: _____	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	☐ Yes ☐ No	☐ Yes ☐ No
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	☐ Yes ☐ No	☐ Yes ☐ No
10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
11. In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No
12. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder?	☐ Yes ☐ No	☐ Yes ☐ No
b. stroke or circulatory disorder (such as peripheral artery disease)?	☐ Yes ☐ No	☐ Yes ☐ No
c. cancer, Hodgkins disease, lymphoma or tumors?	☐ Yes ☐ No	☐ Yes ☐ No
d. anemia, leukemia or other blood disorder?	☐ Yes ☐ No	☐ Yes ☐ No
e. diabetes? Member: Your age at diagnosis?: _____ ☐ Check if insulin treated Spouse/Domestic Partner: Your age at diagnosis? _____ ☐ Check if insulin treated	☐ Yes ☐ No	☐ Yes ☐ No
f. asthma, COPD, emphysema or other lung disease?	☐ Yes ☐ No	☐ Yes ☐ No
g. ulcers, stomach, hepatitis or other liver disorder?	☐ Yes ☐ No	☐ Yes ☐ No
h. colitis, Crohn's, diverticulitis or other intestinal disorder?	☐ Yes ☐ No	☐ Yes ☐ No
i. memory loss?	☐ Yes ☐ No	☐ Yes ☐ No
j. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Member: Specify date of last seizure (month/year) _____ Indicate type _____ Spouse/Domestic Partner: Specify date of last seizure (month/year) _____ Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
k. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐ Yes ☐ No	☐ Yes ☐ No
l. multiple sclerosis, ALS or muscular dystrophy?	☐ Yes ☐ No	☐ Yes ☐ No
m. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐ Yes ☐ No	☐ Yes ☐ No
n. arthritis? Member: ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____ Spouse/Domestic Partner: ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐ Yes ☐ No	☐ Yes ☐ No
o. back, neck, knee, spinal, joint or other musculoskeletal disorder(such as herniated disc; back pain; cervical spondylosis; meniscal, cartilage or ligament tears or injuries; hip fracture; or tendonitis)?	☐ Yes ☐ No	☐ Yes ☐ No
p. carpal tunnel syndrome?	☐ Yes ☐ No	☐ Yes ☐ No
q. kidney, urinary tract or prostate disorder?	☐ Yes ☐ No	☐ Yes ☐ No
r. thyroid or other gland disorder?	☐ Yes ☐ No	☐ Yes ☐ No
s. mental, anxiety, depression, attempted suicide or nervous disorder?	☐ Yes ☐ No	☐ Yes ☐ No
t. sleep apnea?	☐ Yes ☐ No	☐ Yes ☐ No

MEMBER SECTION ONLY

After completing the Personal Physician and Prescription Information, please provide full details in Section 2 for "yes" answers to questions 5 through 12t.

Personal Physician Information

Personal Physician's Name: _____ Telephone: _____

Address (Street, City, State, Zip Code): _____

Date of last visit (MM/DD/YYYY): _____/_____/_____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: _____

Address (Street, City, State, Zip Code): _____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: _____

Address (Street, City, State, Zip Code): _____

☐ Check here if you are attaching another sheet for any additional medications.

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 12t in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your Name _____ Employee's Name _____

Your Date of Birth _____/_____/_____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Physician's Name: _____ Telephone: _____

Date of last visit (MM/DD/YYYY): _____/_____/_____ Reason for visit: _____

Address (Street, City, State, Zip Code): _____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Physician's Name: _____ Telephone: _____

Date of last visit (MM/DD/YYYY): _____/_____/_____ Reason for visit: _____

Address (Street, City, State, Zip Code): _____

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
HEA *applies to residents of Connecticut, North Dakota and Utah)*

After completion, **sign and date the form where indicated.** Make a copy for your records and return to
Employees Club of California, 311 S. Spring Street Suite 1300, Los Angeles, CA 90013

Please Continue this application on the reverse side ▶

SPOUSE/DOMESTIC PARTNER SECTION ONLY

After completing the Personal Physician and Prescription Information, please provide full details in Section 2 for "yes" answers to questions 5 through 12t.

Personal Physician Information

Personal Physician's Name: _____ Telephone: _____

Address (Street, City, State, Zip Code): _____

Date of last visit (MM/DD/YYYY): _____/_____/_____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: _____

Address (Street, City, State, Zip Code): _____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: _____

Address (Street, City, State, Zip Code): _____

☐ Check here if you are attaching another sheet for any additional medications.

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 12t in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your name _____ Employee's Name _____

Your Date of Birth _____/_____/_____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Physician's Name: _____ Telephone: _____

Date of last visit (MM/DD/YYYY): _____/_____/_____ Reason for visit: _____

Address (Street, City, State, Zip Code): _____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Physician's Name: _____ Telephone: _____

Date of last visit (MM/DD/YYYY): _____/_____/_____ Reason for visit: _____

Address (Street, City, State, Zip Code): _____

FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

California: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Member.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security # – –	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security # – –	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security # – –	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL	100%

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (First, Middle, Last)	Social Security # – –	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security # – –	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL	100%

DECLARATIONS AND SIGNATURE

Member

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I declare that I am actively at work on the date I am enrolling.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

Spouse/Domestic Partner

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Spouse/Domestic Partner	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
DEC *applies to residents of Connecticut, North Dakota and Utah)*

LACEA (Class 1) (08/19)

Some services in connection with coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s)("employee", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, Group Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
  - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

Signature of Member _____ Date Signed (MM/DD/YYYY) _____

Print Name _____ State of Birth _____ Country of Birth _____

Sign Here

Signature of Spouse/Domestic Partner _____ Date Signed (MM/DD/YYYY) _____

Print Name _____ State of Birth _____ Country of Birth _____

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

FOR OFFICE USE ONLY

Code	Deduction

CLUB MEMBERSHIP FOR NEW POLICYHOLDERS

Employees Club of California

Enjoy the cheapest tickets in California and save up to 55% off movie theater tickets, theme parks, attractions, sporting events, musical shows, and more exclusively for Club members. With over 75,000 discounts, your Club membership is your passport to everyday savings on shopping, dining, services, travel and more across the United States and Canada.

☑ Club Membership:

Club membership fees will be automatically deducted.

As a new policyholder, you will automatically be enrolled as a member of the Employees Club of California, a membership program of the Los Angeles City Employees Association. Membership is required to participate in group-rated insurance programs. Membership is limited to active or retired employees of the City of Los Angeles, the Department of Water and Power, and California State Employees. As a member of the Employees Club of California, you will have access to many Club-exclusive benefits and programs including the convenience of automatic payroll deduction.