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

L0821015853[exp0823][CA]

Group Term Life Insurance and Accidental Death and Dismemberment Insurance

Exclusively for Retired employees and their spouses/domestic partners

Retiree

EMPLOYEES CLUB OF CALIFORNIA
www.EmployeesClub.com

Insurance from the Club is a dependable, easy choice

As a Government Retiree of the State of California who was an active full-time employee, you are eligible for group rates on Term Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance. You can apply for one or both plans, as an economical way to help better protect your family. Premiums are easy and automatic — they're conveniently deducted each month from your pension or an alternative payment method.

Usually no medical exams to apply!

There's never a medical exam required for AD&D. And there's typically no medical exam required[1] for Term Life Insurance.

Convenient Pension Deduction!

Once your coverage is approved, your premium will be conveniently deducted from your monthly pension check. If the first deductions are unsuccessful, we will bill you until the deductions go through. If you have any questions, please call us at 1-800-464-0452, option 4.

30-day free look:

Should you change your mind after applying, simply return your Certificate of Insurance within 30 days after receiving it for a full refund of any premium paid.

Deal with no-pressure professionals: This coverage is provided through the Employees Club of California, a not-for-profit organization. Our insurance counselors do not work on commission, so they won't try to sell you coverage you don't need. Their goal is to make sure you get the coverage that's right for you and your family.

[1] *Issuance of a Certificate of Insurance may depend upon the answers given in the application and the truthfulness of those answers.*

The Club brings you special savings at theme parks, movies and sports events, plus group rates on auto, homeowners, disability and other insurance coverages.

NOTE: If you are not currently a member of the Employees Club of California, you will automatically be enrolled as a member by applying for insurance coverage. You get all Club benefits for a deduction of only $4.00 per month (retired). You authorize these monthly deductions by signing the enclosed Deduction Authorization form.

Club benefits and programs may change from time-to-time.

Term Life

Eligibility Requirements: A retired member of Los Angeles City Employees Association in good standing; was an active full time employee with 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. You may also insure your dependent child 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 $10,000 or $25,000 of Life Insurance. **Effective Date:** Coverage will be effective on the 1st of the month coinciding with or next following the date your request is approved by Metropolitan Life, provided the required premium is paid. **Date Insurance Ends:** As long as you continue to pay premiums when due, you continue to be a member in an eligible class, the group policy remains in effect and insurance does not end for your class, your coverage will not end. With respect to spouse or domestic partners, as long as the person remains the spouse or domestic partner of the member, coverage will not end. **Exclusions:** Certain exclusions apply. 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. See your Certificate of Insurance for details.

AD&D

Eligibility Requirements: A retired member of Los Angeles City Employees Association in good standing; was an active full time employee with 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 the Family Plan is selected, you may also insure your lawful spouse/domestic partner and dependent children at least 15 days up to 26. **Effective Date:** Coverage will take effect on the date MetLife states in writing, provided the required premium is paid. **Date Insurance Ends:** As long as you continue to pay premiums when due, you continue to be a member in an eligible class the group policy remains in effect, and insurance does not end for your class, your coverage will not end. Coverage for your spouse/domestic partner and children, if enrolled, will cease when your insurance ends, or with respect to spouses, the date marriage ends by divorce or annulment. With respect to children, the date eligibility ends. And with respect to domestic partners, the date he or she ceases to be a domestic partner of the member. **Exclusions:** 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.

Group Coverage Exclusively for Club Members

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

Group Term Life Insurance

Term Life for as little as $5.10 per month

It couldn't be easier to provide your spouse/domestic partner and family with up to $50,000 of Term Life Insurance protection, at economical group rates — for example, a 60-year-old can get $10,000 of coverage for $17.50 a month (see rate chart for costs for all ages and other benefit amounts). You can elect coverage between $10,000 and $50,000.

Quick and easy to buy

Refer to the Rate Chart to find your economical group rate, based on your current age. Then select the premium amount most comfortable for your budget — for benefit amounts of $10,000 to $50,000.

Fair pricing built right in

If we collect more premium than we end up needing for claims and expenses, we may give the excess back to you! Since 1928, with a few exceptions, insured members have received a Term Life premium refund that can help offset your premium costs.

Monthly Cost for Term Life

	Benefit Amount		
Age	$10,000	$30,000	$50,000
50-54	$5.10	$15.30	$25.50
55-59	$8.60	$25.80	$43.00
60-64	$17.50	$52.50	$87.50
65-69	$32.00	$96.00	$160.00
70-74*	$42.00	$126.00	$210.00
75+*	$63.00	$189.00	$315.00

* You must be under Age 70 to apply for coverage. Rates shown for ages 70+ are Renewal Rates only. 50% benefit reductions will occur at age 70, age 75 and 80. Maximum benefit at age 85 will be $10,000. Please see your Certificate of Coverage for complete details.

One Step Express Underwriting

For Ages 50 to 59

Members and Spouses/Domestic Partners, age 50 to 59 may apply for coverage using the enclosed short form application. The form includes only 6 medical questions and asks for your height and weight. If we find no further medical information is needed upon review of your application, then you're approved. It's as easy as that!

For members age 60 to 69, please call 1-800-464-0452, option 4 to request your application.

Even if you or your spouse/domestic partner do not meet the above requirements, you can still apply for $10,000, up to $50,000, with approval based on your medical history and/or a medical exam.

[1] *Issuance of a Certificate of Insurance may depend upon the answers given in the application and the truthfulness of those answers.*

Group Accidental Death and Dismemberment Insurance

Get $10,000 in coverage for $1.50 a month

An economical way to add to your family's insurance protection is with Accidental Death and Dismemberment Insurance (AD&D), which pays your beneficiary the benefit you select should you die due to injury caused by a covered accident. It also pays a benefit for specific injuries, as outlined below.

There's never a medical exam required to apply, and there are no health questions to answer. And the cost is as economical as $1.50 for $10,000, regardless of your age (see costs below). You may apply for up to $150,000.

Plan includes spouse/domestic partner and child coverage

If the Family Plan is selected, your spouse/domestic partner is automatically insured for 50% of your full benefit amount, and each dependent child is insured for 20% of your full benefit amount. Dependent children can be insured if they are age 15 days to age 26. If you have no dependent children, your spouse/domestic partner will be insured for 60% of your full benefit amount; if you have no spouse/domestic partner but you do have dependent children, each dependent child will be insured for 25% of your full benefit amount.

Monthly Cost for AD&D

Benefit Amount	Individual Plan Monthly Cost	Family Plan Monthly Cost
$ 10,000	$ 1.00	$ 1.50
20,000	2.00	3.00
30,000	3.00	4.50
40,000	4.00	6.00
50,000	5.00	7.50
75,000	7.50	11.25
100,000	10.00	15.00
150,000	15.00	22.50

AD&D benefit summary

Accidental death coverage: Pays 100% of the benefit amount you select for loss of life due to a covered accident. The plan also includes benefits for: education of insured dependent children if the insured member dies; retraining for a surviving spouse/domestic partner; and wearing a seat belt at the time of an auto accident. (see Certificate of Insurance for specific benefit amounts).

Accident-related dismemberment coverage: Pays 100% of the benefit amount you select for loss of both hands, both feet, sight of both eyes, loss of both speech and hearing, quadriplegia, or any combination of a foot, hand or sight of one eye.

- **Pays 50% of the benefit amount** for paraplegia
- **Pays 50% of the benefit amount** for loss of sight of one eye, or loss of one hand, one foot, or speech or hearing, or hemiplegia
- **Pays 25% of the benefit amount** for loss of thumb and index finger of either hand

Please refer to your Certificate of Insurance for definitions of specific losses.

Quick and Easy Application Process

Members age 50 to 59, just complete and mail the enclosed application to:

Employees Club of California
311 S. Spring St., Suite 1300
Los Angeles, CA 90013

For members age 60 to 69, please call 1-800-464-0452, option 4 to request your application.

MetLife

ENROLLMENT • CHANGE FORM

Metropolitan Life Insurance Company, New York, NY 10166

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 (LACEA)	**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 Retirement (MM/DD/YYYY)

Home 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

☐ Supplemental/Optional Life[1]

☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐ $30,000 ☐ $35,000 ☐ $40,000 ☐ $45,000 ☐ $50,000

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

☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐ $30,000 ☐ $35,000 ☐ $40,000 ☐ $45,000 ☐ $50,000

☐ Dependent Child Life[3]

☐ $10,000 ☐ $25,000

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

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000

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

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.

Your height _____ feet _____ inches	Spouse/Domestic Partner height _____ feet _____ inches	**Member**	**Spouse/ Domestic Partner**
Your weight _____ pounds	Spouse/Domestic Partner weight _____ pounds		
1. 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
2. Are you now receiving or applying for any disability benefits, including workers' compensation?		☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?		☐ Yes ☐ No	☐ Yes ☐ No
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.			
4. 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
5. 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
6. 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, Hodgkin's disease, lymphoma or tumors?		☐ Yes ☐ No	☐ Yes ☐ No
d. diabetes?		☐ Yes ☐ No	☐ Yes ☐ No
e. asthma, COPD, emphysema or other lung disease?		☐ Yes ☐ No	☐ Yes ☐ No

If you answered "yes" to any of the above questions, a Statement of Health form must also be completed for the person to whom the "yes" applies.

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)*

FRAUD WARNINGS

Before signing this enrollment 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)*

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

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

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)

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)*

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) ("member", spouse, and /or 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.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- 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.