Get SOLID paycheck coverage

With just your limited sick time or salary continuation program and no State Disability Insurance (SDI), Long Term Disability from the Club is more than optional — it's vital! Fill out and return the application form or call a Club counselor at (800) 464-0452, Option 4.

Whether you're disabled on or off the job…

- **THE PLAN** pays the lesser of 60% of your gross pay, or 70% of your gross pay less other income paid to you for the same disability. The maximum monthly benefit is $10,000.
- **THE PLAN** pays to age 65 (if you become disabled before 60).
- **THE PLAN** benefit payments are usually tax-free! Consult your tax advisor.

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, elimination periods, and terms for keeping them in force. Please contact your plan administrator for costs and complete details.

Underwritten by:

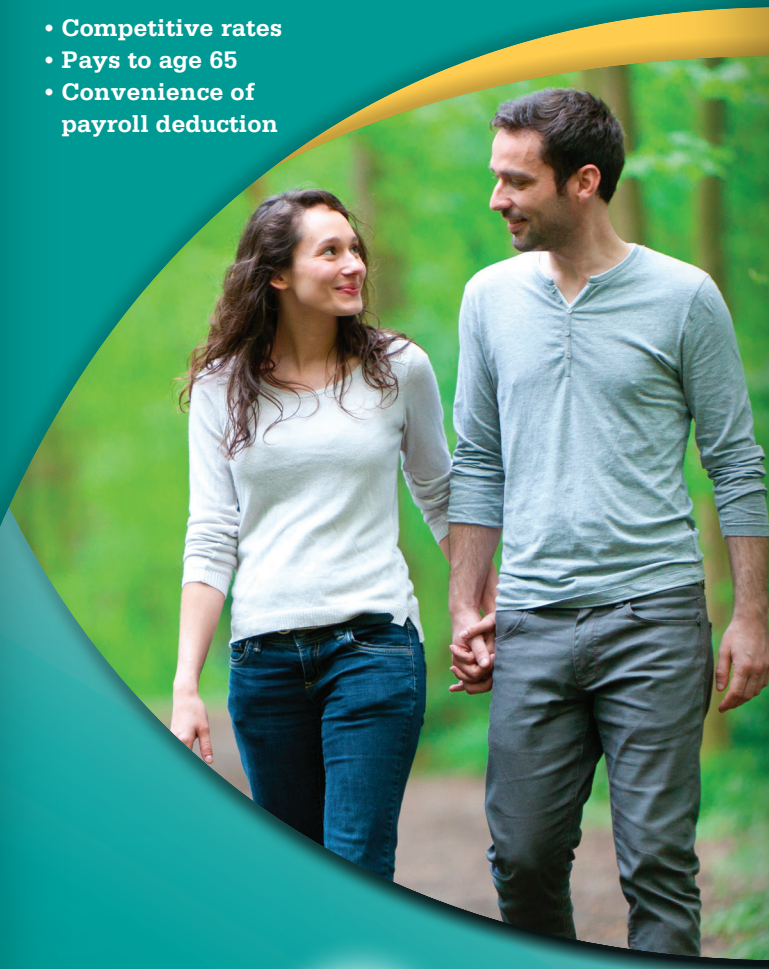
MetLife

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

Group Long Term Disability Insurance

How would you pay the bills if you couldn't work?

- **Competitive rates**
- **Pays to age 65**
- **Convenience of payroll deduction**



EMPLOYEES CLUB OF CALIFORNIA
www.EmployeesClub.com

Additional group long term disability insurance coverage information

Eligibility Requirements

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 at least 30 hours per week for the City of Los Angeles and

- an electrical craft workers; or
- eligible for the City Retirement System or the Department of Water and Power pension

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.

Duration of Benefits

Monthly benefits will be paid up to the maximum benefit period. The benefit will end on the date you fail to give required proof of continuing disability or verification of earnings as needed, your disability ends, the maximum benefit period ends, or you die. Once the elimination period has been satisfied, benefits for a disability which begins prior to age 60 are payable to age 65. However, if your disability begins after age 60, the following schedule applies:

if total disability begins prior to age 60:		to age 65
if total disability begins at attained age:	60	60 months
	61	48 months
	62	42 months
	63	36 months
	64	30 months
	65	24 months
	66	21 months
	67	18 months
	68	15 months
	69 and over	12 months

Date Member's Insurance Ends

Insurance will end at the earliest of: the date this policy ends; the date insurance ends for your class; the date you cease to be a member; the date the Los Angeles City Employees Association ceases to be a participating unit; the end of the period for which the last premium has been paid; or the date you cease to be actively at work on a full-time basis, except for a leave of absence. If you are on a leave of absence and continue to pay premiums, your insurance will be continued.

Total Disability

Total Disability means:

- during the Elimination Period and the next 24 months, the member is unable to perform with reasonable continuity the substantial and material acts necessary to pursue the member's usual occupation in the usual and customary way.
- after such period, the member is not able to engage with reasonable continuity in any occupation in which the member could reasonably be expected to perform satisfactorily in light of the member's: age; education; training; experience; station in life; and physical and mental capacity.

The total disability must be a result of an injury or sickness. For purposes of determining whether a Disability is the direct result of an injury, the Disability must have occurred within 90 days of the injury and not as a result of Sickness.

Basic Monthly Pay

Basic Monthly Pay means your monthly rate of pay from your employer. Such rate will be that in effect on the day before disability begins. "Basic monthly pay" does not include commissions, bonuses, overtime pay or other extra compensation.

Pre-existing Conditions

PRE-EXISTING CONDITION means an injury or sickness for which you: received medical treatment, care or services for a diagnosed condition, or took prescribed medication for a diagnosed condition, in the 6 months immediately prior to the effective date of coverage under this certificate; and the Disability caused or substantially contributed to by the condition begins in the first 12 consecutive months after the effective date of coverage under this certificate.

The member is not covered for a Disability caused or substantially contributed to by a Pre-existing Condition or medical or surgical treatment of a Pre-existing Condition.

LIMITED DISABILITY BENEFITS:

- If you are disabled due to Mental or Nervous Disorder or disease, except for: schizophrenia; dementia; bi-polar disorder; organic brain disease, your Disability benefits will be limited to a lifetime maximum of 12 months or the Maximum Benefit Period, whichever is less.
- If you are disabled due to alcohol, drug or substance abuse or addiction, your Disability benefits will be limited to a lifetime maximum of 12 months or the Maximum Benefit Period, whichever is less.
- If you are disabled due to Neuromuscular, Musculoskeletal or soft tissue disorder, your Disability benefits will be limited to a lifetime maximum of 24 months or the Maximum Benefit Period, whichever is less.
- If you are disabled due to Chronic Fatigue Syndrome and Related Disorders, your Disability benefits will be limited to a lifetime maximum of 12 months or the Maximum Benefit Period, whichever is less.

Exclusions

We will not pay for any Disability caused or contributed to by war, whether declared or undeclared, or act of war, insurrection, or rebellion; your active participation in a riot; intentionally self-inflicted injury; attempted suicide or commission of or attempt to commit a felony. Please refer to your certificate for complete details.

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.

Here's how Long Term Disability Insurance from the Club could help PROTECT your paycheck:

DWP EMPLOYEES

What you have through the DWP:

- **Salary Continuation Up To 1 Year:** 100% falling to only 40% of your salary
- **One-Year Extended Salary Continuation:** Just 33% of your salary
- **Permanent Total Disability:** Just 40% of your salary

That's it. Don't forget, DWP employees don't qualify for State Disability Insurance (SDI).

What you can ADD with the Club:

Once you are Totally Disabled and your elimination period ends, the benefits payable are: the lesser of 60% of your gross pay, or 70% of your gross pay less other income paid to you for the same disability. The maximum monthly benefit is $10,000.[1] And it's usually tax-free![†]

How much does it cost? (See premiums chart at right)

1. First, choose your elimination period. We recommend:

Less than 10 years of service:	90 days
10+ years of service:	180 days
30+ years of service:	360 days

Remember, the longer you can afford to wait, the more economical your premium will be. The elimination period starts the day your disability begins and runs concurrently with your other sick time or salary continuation benefits. If, during the elimination period, your disability stops for 30 days or less, the disability will be treated as continuous. The days you were not disabled will not count towards satisfying the elimination period.

2. Then complete the worksheet below:

	Example	You
Elimination Period	180 days	_____ days
Yearly gross salary	$ 48,000	$ _____
Divide by 24	$ 2,000	$ _____
Divide by 100	$ 20	$ _____
Rate (from chart, right)	X $ .74	X $ _____
Bi-weekly deduction	**$ 14.80**	$ _____

(Example: employee age 43, 15-19 years of service.)

[†] Please consult your tax advisor.

CITY* EMPLOYEES

What you have through the CITY:

- **Sick Time 3 Weeks To 10 Months:** Depending on accumulated sick time
- **Two-Year Taxable Disability Benefit:** Just 50% of your salary
- **Disability Retirement:** Just 33% of your salary (and only after five years of service!)

That's it. Don't forget, City employees don't qualify for State Disability Insurance (SDI).

What you can ADD with the Club:

Once you are Totally Disabled and your elimination period ends, the benefits payable are: the lesser of 60% of your gross pay, or 70% of your gross pay less other income paid to you for the same disability. The maximum monthly benefit is $10,000.[1] And it's usually tax-free![†]

How much does it cost? (See premiums chart at right)

1. First, choose your elimination period. We recommend:

Less than 880 hours of 100% + 75% Sick Time:	90 days
880-1700 hours of 100% + 75% Sick Time:	180 days
More than 1700 hours of 100% + 75% Sick Time:	360 days

Remember, the longer you can afford to wait, the lower your premium will be. The elimination period starts the day your disability begins and runs concurrently with your other sick time. If, during the elimination period, your disability stops for 30 days or less, the disability will be treated as continuous. The days you were not disabled will not count towards satisfying the elimination period.

2. Then complete the worksheet below:

	Example	You
Elimination Period	180 days	_____ days
Yearly gross salary	$ 48,000	$ _____
Divide by 24	$ 2,000	$ _____
Divide by 100	$ 20	$ _____
Rate (from chart, right)	X $ .74	X $ _____
Bi-weekly deduction	**$ 14.80**	$ _____

(Example: employee age 43.)

**Call a Club Counselor at (800) 464-0452 option 4 for Plan coordination with your Flex Benefits.*

The Club

With additional coverage from the Club, you restore income you might lose without it!

The Plan

helps restore a portion of your income!

The Plan can pay up to 70% (less other income) or 60% of your gross salary to help refill a portion of your glass!

Monthly Rate Per $100 of Monthly Covered Payroll

Age	Elimination period		
	90 days	180 days	360 days
To 29	$0.68	$0.45	$0.39
30-34	0.69	0.49	0.45
35-39	0.83	0.63	0.56
40-44	1.00	0.74	0.68
45-49	1.40	1.09	0.98
50-54	1.93	1.41	1.29
55-59	2.76	2.10	1.86
60-64	3.35	2.33	2.09
65+	4.97	3.06	2.69

[1] The amount of monthly benefit is the maximum benefit you will receive under the policy. The benefit will be reduced by any other benefits you are entitled to receive from sources, including amounts you're eligible for under Workers' or Workmen's Compensation Law, occupational disease law or any other similar act or law; employer continuation/sick leave benefits; disability from any compulsory benefit act/law or group insurance plan; Social Security Disability benefit; or employer or governmental retirement plan.

Sign up for Group Long Term Disability

Insurance from the Club.

Imagine the possibility of living on less than half of your pay!

If you happen to suffer a long-term illness or injury, that's all you might get with the disability coverage you have now.

Long Term Disability (LTD) benefits from the Plan BEGIN when you need them most.

Long Term Disability Insurance starts helping to support you and your family as soon as your elimination period ends. Whether your disability happened on or off the job, the Plan will pay the lesser of 60% of your gross pay, or 70% of your gross pay less other income paid to you for the same disability. The maximum monthly benefit is $10,000. Even when your other sources are used up, we pay 60% of your gross salary to age 65, for as long as you are disabled.

Your Club LTD benefits are usually tax-free!*

Right now, you probably take home about 70% to 80% of your gross pay after taxes. Since you pay the premiums, the money you receive from this LTD insurance is usually tax-free — meaning your take-home pay can stay very close to what it was before you were disabled.

High quality, competitive premiums.

LTD from the Club is underwritten by Metropolitan Life Insurance Company, New York, NY. Because the Club is a membership program of the Los Angeles City Employees Association, a not-for-profit association, you get MetLife's quality LTD coverage at an economical price. MetLife is one of America's most respected insurance companies.

Take the next step now!

Use the easy worksheet to see how Long Term Disability Insurance from the Club would complement your benefits.*

TO APPLY

Just fill out the application and mail it today!

** Please consult your tax advisor.*

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)
Basic Annual Earnings $	Job Title	
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.

▶ You must complete the Health Information section of this form and the enclosed Authorization form.

Disability Income Insurance

☐ **Long Term Benefits**

Select your Elimination Period:

☐ 90 Days ☐ 180 Days ☐ 360 Days

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
1. Member's height _____ feet _____ inches Member's weight _____ pounds	
2. Are you now on a diet prescribed by a physician or other health care provider?	☐ Yes ☐ No
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐ Yes ☐ No
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐ 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
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) _____	☐ 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
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐ Yes ☐ No
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?	☐ 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.	
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
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
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
b. stroke or circulatory disorder (such as peripheral artery disease)?	☐ Yes ☐ No
c. cancer, Hodgkins disease, lymphoma or tumors?	☐ Yes ☐ No
d. anemia, leukemia or other blood disorder?	☐ Yes ☐ No
e. diabetes? Member: Your age at diagnosis?:_____ ☐ Check if insulin treated	☐ Yes ☐ No
f. asthma, COPD, emphysema or other lung disease?	☐ Yes ☐ No
g. ulcers, stomach, hepatitis or other liver disorder?	☐ Yes ☐ No
h. colitis, Crohn's, diverticulitis or other intestinal disorder?	☐ Yes ☐ No
i. memory loss?	☐ Yes ☐ No
j. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Member: Specify date of last seizure (month/year) _____ Indicate type _____	☐ Yes ☐ No
k. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐ Yes ☐ No
l. multiple sclerosis, ALS or muscular dystrophy?	☐ Yes ☐ No
m. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐ Yes ☐ No
n. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐ 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
p. carpal tunnel syndrome?	☐ Yes ☐ No
q. kidney, urinary tract or prostate disorder?	☐ Yes ☐ No
r. thyroid or other gland disorder?	☐ Yes ☐ No
s. mental, anxiety, depression, attempted suicide or nervous disorder?	☐ Yes ☐ No
t. sleep apnea?	☐ 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.

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 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

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	Your Date of Birth (MM/DD/YYYY)	Employee's Name

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	**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	**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 North Dakota and Utah)*

DECLARATIONS AND SIGNATURE(S)

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 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 North Dakota and Utah)*

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) ("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

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