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:

City Employees Club of Los Angeles
311 South Spring Street, Suite 1300
Los Angeles, CA 90013
(800) 464-0452
www.cityemployeesclub.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 MetLife or 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

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L0118502032[exp0119][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/DWP Active

CITY EMPLOYEES CLUB OF LOS ANGELES
www.CityEmployeesClub.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 own 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.

City Employees Club of Los Angeles
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 40 hours per week for the City of Los Angeles or the Department of Water and Power; must be eligible for the City Retirement System or the Department of Water and Power Pension plan (except for Electrical Craft Workers). 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 Physican'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.

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 40 hours per week for the City of Los Angeles or the Department of Water and Power; must be eligible for the City Retirement System or the Department of Water and Power Pension plan (except for Electrical Craft Workers).

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 City Employees Club of Los Angeles 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 would make ends meet if they could no longer rely on your income? Almost four in 10 American households have no life insurance, while 85% of those surveyed say most people need life insurance.[1] If you haven't helped protect your family with life insurance yet, it's time to discover how economical it can be. And 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.*

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

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.

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 leave the City or DWP or if you retire.

Economical Group Term Life Rates

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

Dependent coverage costs $3.00, bi-weekly.

DWP paycheck deductions occur once a month instead of bi-weekly; to calculate deductions for DWP employees, multiply bi-weekly rates by two.

*** 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.

** 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.*

[1] www.lifehappens.org/insurance-overview, viewed 9/14,
[2] National Safety Council: 2013 Injury Facts

Accidental Death and Dismemberment Insurance

Accidents are the leading cause of death for Americans under age 45 and the fourth leading cause of death among people of all ages.[2] In addition, a disabling injury occurs every second in this country, and nearly every four minutes an accident claims another American life.[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. Get the Family Plan for only $1.00 bi-weekly per $25,000 of coverage.

Quick And Easy Application Process

As a City Employees Club of Los Angeles 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: City Employees Club of Los Angeles, 311 S. Spring St., Suite 1300, Los Angeles, CA 90013. For members age 60 and over, please call 1-800-464-0452 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.

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 (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 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

☐ Supplemental/Optional Life[1]

Under age 40: Enter a multiple of $10,000 up to a maximum of $250,000. $ ____________________

Age 40 to 49: Enter a multiple of $10,000 up to a maximum of $150,000. $ ____________________

Age 50 to 59: Enter a multiple of $10,000 up to a maximum of $100,000. $ ____________________

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

Under age 40: Enter a multiple of $10,000 up to a maximum of $250,000. $ ____________________

Age 40 to 49: Enter a multiple of $10,000 up to a maximum of $150,000. $ ____________________

Age 50 to 59: Enter a multiple of $10,000 up to a maximum of $100,000. $ ____________________

☐ 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.

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.

		Member	Spouse/ Domestic Partner
Your height _____ feet _____ inches	Spouse/Domestic Partner height _____ feet _____ inches		
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

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; and*
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; and*
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
City Employees Club of Los Angeles, 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; and*
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)("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

Send no money now!

If applying by mail, complete the application and payroll deduction form and return to:

City Employees Club of Los Angeles
311 South Spring Street, Suite 1300 • Los Angeles, CA 90013

Complete and sign this Payroll Deduction Authorization as part of your Insurance application.

Payroll Deduction Authorization

Membership is open to all active and retired City of Los Angeles and DWP employees.

In addition to payroll/pension deductions for group benefits, if any, you will receive all Club benefits for a payroll/pension deduction of only $6.00 per month (active employees) or $4.00 per month (retired). You authorize these monthly deductions by signing the Payroll Deduction Authorization form.

Name: ______________________ City Department #: ____

(5 or 6 digits)
❍ City Employee #: ______ ❍ DWP Employee #: ______ ❍ Retired City Employee SSN#: ___ - __ - ____

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 on any of my group benefits provided by the **City Employees Club.** In the event any premiums should change due to age, increase in salary or benefits, or a general rate increase for the entire Association, I authorize you to make such change upon notification from the City Employees Club and such deduction to remain in force until canceled by me in writing.

City Employees Club
311 South Spring Street, Suite 1300
Los Angeles, CA 90013
1-800-464-0452
info@cityemployeesclub.com
www.cityemployeesclub.com

Please select one:
❍ City Active ❍ DWP Active
❍ City Retired ❍ DWP Retired
❍ Fire/Police Pension (Officers Only)

Sign Here

Sign Here X ______________________

City/DWP Employee Date

FOR OFFICE USE ONLY

Code Deduction

CLUB MEMBERSHIP NEW POLICYHOLDERS:

Club membership fees will be automatically deducted.

☑ Club Membership:

As a new policyholder, you will automatically be enrolled as a member of the City Employees Club of Los Angeles, 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 and the Department of Water and Power. As a member of the City Employees Club of Los Angeles, you will have access to many Club-only benefits and programs including:*

Discount Tickets Through the Club Store

- Buy tickets by phone, mail, or by the Club website at www.cityemployeesclub.com
- Theme parks and attractions
- Movies – most major screens
- Plays, musicals, the arts, sports events

More Discounts and Savings

- Enjoy exclusive Club savings from Club partner businesses

Monthly Alive! Newspaper

- Births, weddings, retirements, deaths
- Free classifieds
- Retiree's Corner
- News that matters
- Department of the month
- Opinion column, movie reviews
- Latest Club information

Group-Rated Insurance Products

- Term Life Insurance
- Spouse Life Insurance
- The famous "Refund Check"
- Long Term Disability Insurance
- Short Term Disability Insurance
- Long Term Care Insurance
- Cancer Insurance
- Group-Rated Accidental Death & Dismemberment Insurance
- Group-Rated Auto and Homeowners Insurance
- Pet Insurance
- Legal Services Plan
- Accident Insurance
- Identity Theft Protection

More Benefits

- Free notary service
- Scholarships
- Employee of the Year Award

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