Employees Club of California

Disability Income Plus Rates

MONTHLY DEDUCTIONS:

Twelve month benefit period with 14/14 elimination period

Non-Occ Coverage with Mental Health Benefit

MONTHLY PREMIUM				
Benefit Amount	**Age 18-39**	**Age 40-49**	**Age 50-59**	**Age 60+**
$500	$20.55	$23.70	$33.20	$42.70
$600	$24.66	$28.44	$39.84	$51.24
$700	$28.77	$33.18	$46.48	$59.78
$800	$32.88	$37.92	$53.12	$68.32
$900	$36.99	$42.66	$59.76	$76.86
$1,000	$41.10	$47.40	$66.40	$85.40
$1,100	$45.21	$52.14	$73.04	$93.94
$1,200	$49.32	$56.88	$79.68	$102.48
$1,300	$53.43	$61.62	$86.32	$111.02
$1,400	$57.54	$66.36	$92.96	$119.56
$1,500	$61.65	$71.10	$99.60	$128.10
$1,600	$65.76	$75.84	$106.24	$136.64
$1,700	$69.87	$80.58	$112.88	$145.18
$1,800	$73.98	$85.32	$119.52	$153.72
$1,900	$78.09	$90.06	$126.16	$162.26
$2,000	$82.20	$94.80	$132.80	$170.80
$2,100	$86.31	$99.54	$139.44	$179.34
$2,200	$90.42	$104.28	$146.08	$187.88
$2,300	$94.53	$109.02	$152.72	$196.42
$2,400	$98.64	$113.76	$159.36	$204.96
$2,500	$102.75	$118.50	$166.00	$213.50
$2,600	$106.86	$123.24	$172.64	$222.04
$2,700	$110.97	$127.98	$179.28	$230.58
$2,800	$115.08	$132.72	$185.92	$239.12
$2,900	$119.19	$137.46	$192.56	$247.66
$3,000	$123.30	$142.20	$199.20	$256.20

Who is ManhattanLife?

The Employees Club of California has joined with ManhattanLife to offer short-term disability coverage at great rates.

ManhattanLife Insurance Company of America, headquartered in Houston, Texas, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being.

ECC-ManhattanLife DIP 2022

Disability Income Plus underwritten by:
ManhattanLife Assurance Company of America

Employees Club of California
311 S. Spring Street
Suite 1300
Los Angeles, CA 90013-9844
(800) 464-0452
www.employeesclub.com

ManhattanLife Disability Income Plus

Short Term Disability Insurance

EMPLOYEES CLUB OF CALIFORNIA
www.EmployeesClub.com

DISABILITY INCOME INSURANCE:

Group Disability Coverage You Need When it Counts Most

Did you ever think about what would happen to your family if you suddenly lost the ability to bring home a paycheck? With **ManhattanLife Disability Income Plus** you won't have that worry. You'll enjoy a valuable benefit to help supplement lost wages due to a covered injury or illness that occurs off the job. You will receive a payment to spend however you wish — to help cover everyday expenses, medical costs, and more. Plus, this disability plan pays in addition to any existing disability coverage you may have.

What does ManhattanLife Disability Income Plus cover?

You'll receive a cash benefit paid directly to you for the following:

- Off-the-job injuries or illnesses
- Pre-existing conditions causing a loss after 12 months of coverage.
- Pregnancy leave

Here's how it works:

- Benefit is paid after the elimination period has been satisfied, which is the number of continuous days beginning with the first day of total disability.
- Pays regardless of any other disability or income.
- Pay premiums conveniently through automatic payroll deduction.
- Coverage guaranteed renewable if actively at work.

Additional plan information:

- Coverage type – Guaranteed renewable to age 70, non-occupational disability income insurance policy that provides a monthly income for total disability as a result of an accidental injury or sickness and inability to work due to a non-occupational accidental injury or sickness.
- Benefit amount – Up to the selected percentage of income per month. Minimum $500; maximum $3,000 in $100 increments. You can protect up to 65% of your gross monthly pay.
- Elimination period – Covers off-the-job injuries/ sicknesses after 14 days of total disability.
- Benefit period – Twelve months.

This disability plan offers coverage for the following:

- Sickness includes Total Disability due to normal pregnancy after you have been insured for 12 months. A total disability beginning 12 months after the effective date of the policy and due to normal pregnancy will be covered, subject to the elimination period.
- Waiver of premium included after 90 days of total disability.
- A 50% benefit up to 6 months is included for partial disability upon returning to work part time after a total disability provided maximum has not been reached.
- If you become disabled again within 180 days of returning to work, the elimination period is waived, and remaining benefits are immediately available.
- If disabled due to a mental illness or substance abuse, plan pays up to 6 months of benefit.

Questions?

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

(800) 464-0452

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311 S. Spring St., Ste 1300
Los Angeles, CA 90013
www.employeesclub.com

Definition of Total Disability:

- You are unable to perform with reasonable continuity the substantial and material acts necessary to pursue Your usual occupation in the usual and customary way; or
- You are unable to engage with reasonable continuity in another occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, physical and mental capacity.

Add this valuable coverage

ManhattanLife Disability Income Plus is an excellent way to add an extra layer of protection if you are unable to bring home a paycheck — even if you are injured on a weekend you'll be covered!

Enrollment is easy. There are only a few questions to answer to get valuable coverage that will give you and your family greater financial peace of mind.

This is not a complete disclosure of plan qualifications and limitations. Please access our website to obtain a completed list for the Workplace Voluntary Benefit product at Disclosure.ManhattanLife.com. Please review this information before applying for coverage. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made. This policy has limited benefits. ManhattanLife Policy: M-8014

Enrollment Form for Voluntary Group Disability Income Benefits

ManhattanLife. Standing By You. Since 1850.

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

Section A: Always complete this Section with Proposed Insured's information for all coverages.

Proposed Insured (Please Print)

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

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

Address (Street or R.R.)

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

Employer Name or Group Number: L A C E A | Date of Employment (MM/DD/YYYY) / /

Annual Salary $ | Occupation

BENEFITS

● **DISABILITY INCOME COVERING ACCIDENT AND SICKNESS**

Benefit Group (If applicable)	Benefit Period	Elimination Period	Monthly Benefit	Total Monthly Premium
❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5	● 1 Year	● 14/14	$,	$.

Section B: Always Complete this Section.	Proposed Insured
1. Are you currently actively at work? (Performing the normal duties of your occupation on a full-time basis, at the employer's usual place of business or off-site working opportunities sanctioned by the employer, and is not partially disabled)	☐ Yes ☐ No
2. How many hours per week do you work?	
3. Do you have any other disability income coverage in force or an Application/Enrollment Form for disability insurance pending with this or any other company?	☐ Yes ☐ No
4. Have you used any form of tobacco in the past 12 months?	☐ Yes ☐ No

Section C: Complete Questions 5-9 and Questions 1-4 if applying for Simplified Issue.	Proposed Insured
5. Have you missed 5 or more consecutive days of work in the past 12 months for any injury or illness other than cold, flu or maternity?	☐ Yes ☐ No
6. Have you ever been treated or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
7. In the past 12 months, have you been treated or diagnosed for cancer (except basal cell skin cancer), insulin dependent diabetes or cirrhosis?	☐ Yes ☐ No
8. In the past 5 years have you been treated or diagnosed for any of the following: heart attack, heart surgery, heart disease, high blood pressure reading of 140/90 or above, stroke, transient ischemic attack (TIA), cancer (except basal cell skin cancer), end stage renal/kidney disease, arthritis, joint displacements, diabetes, emphysema, lung disease, liver disease, hepatitis, cirrhosis, neurological disorder, multiple scleriosis, chronic fatigue syndrome, fibromyalgia, digestive/intestinal disease, acohol or drug usage outside of prescribed use?	☐ Yes ☐ No
9. Please provide Height and Weight. Height (Ft-In)	Weight

ECC-ManhattanLife DIP 2022

ENROLLMENT FROM
continued

AGREEMENTS

PROPOSED INSURED'S REPRESENTATION AND AGREEMENT

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

Signed at: _____ (City) _____ (State) _____ / _____ / _____ (Date (MM/DD/YYYY))

_____

Signature of Proposed Insured/Owner

False statements in an application do not bar the right to recovery under the policy unless: 1) such false statement was made with the intent to deceive; or 2) the false statement materially affected the insurers acceptance of the risk or the hazard assumed by the insurer.

PRODUCER CERTIFICATION

INSURANCE PRODUCER'S USE ONLY

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

Signature of Licensed Insurance Producer _____ (Not required)

Date (MM/DD/YYYY) _____ / _____ / _____

Insurance Producer Number (_____) _____ - _____

% Credit _____

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

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