LA COUNTY FIRE FIGHTERS

Local 1014 Membership Application And Benefits Enrollment Form

1. REASON FOR REQUEST

I am applying for (check all that apply):

☐ Local 1014 union membership *(attach $10)*
- ☐ **Coverage under Local 1014 medical plan** ***(must be a member of 1014)****
- ☐ **State Spouse's Medical Plan (if any)**_____
- ☐ Voluntary life insurance *(must be a member of 1014)*
- ☐ Protect your Income (PYI) Insurance (must be a member of 1014)
- ☐ Voluntary accidental death/dismemberment insurance *(must be a member of 1014)*
- ☐ Membership reinstatement in Local 1014 (attach $11)**
- ☐ Are you transferring from another IAFF local? If yes:

- Name of Local _____ Local # _____
- International Association member # _____
- Is membership current? ☐ Yes ☐ No

☐ Declining coverage under Local 1014 medical plan *(must have coverage under another medical plan)*

* *New hires as fire fighters, annual open enrollment and qualified change in status only.*

***Application for reinstatement is subject to Executive Board approval. Contact Local 1014 for statement of arrearages, if any.*

2. DATA

Name (Last, First, Middle)	**Birthdate** / /	**Social Security #** - -	☐ Male ☐ Female	**Employee #**
Address	**Home Phone** ( )	**Work Phone** ( )	**E-Mail**	
City/State/ZIP	**Marital Status:** ☐ Married (date): _____ ☐ Single ☐ Divorced ☐ Separated		**Member Status** ☐ Active ☐ Retired	**Hire Date**
Work Location (Shift)	**New Hires as Fire Fighters: Are you currently a "permanent status" LA County employee?** ☐ Yes ☐ No			

New Hires: Are you paying dues to a Los Angeles County union? ☐ Yes ☐ No **If "Yes," give union name and local #:**	**New Hires as Fire Fighters: If you are a "permanent status" Los Angeles County employee, what is your payroll title?** *List Title Here:*

3. DEPENDENT INFORMATION

If you are enrolling for coverage under the Local 1014 medical plan, please complete the following information for each person you are enrolling, including your spouse and any dependent children: **Attach proof of dependent status (e.g., marriage certificate, birth certificate, adoption papers, etc.).**

Relationship	Enrollee's Name (Last, First, MI)	Date Of Birth	Age	Social Security #	F/T Student?	Is enrollee totally disabled?	
Spouse M/F				- -	Yes / No	Yes / No	Date:
Child M/F				- -	Yes / No	Yes / No	Date:
Child M/F				- -	Yes / No	Yes / No	Date:
Child M/F				- -	Yes / No	Yes / No	Date:
Child M/F				- -	Yes / No	Yes / No	Date:
Child M/F				- -	Yes / No	Yes / No	Date:

4. VOLUNTARY LIFE INSURANCE

As an active union member of Local 1014, you are automatically covered for $10,000 of life insurance. Also, you have the option of purchasing additional coverage for yourself and your eligible dependents. Eligible dependents include your spouse and unmarried children under age 19 if they depend on you for financial support (through age 25 if full-time student). To enroll for additional coverage, please check the appropriate box below to indicate which coverage(s) you would like to purchase:

Type	Coverage Amount
☐ **Option 1** (additional life)	$10,000 double indemnity (through Provident Life And Accident Insurance Company)
☐ **Option 2** (supplemental life)	$10,000 double indemnity (through Provident Life And Accident Insurance Company)
☐ **Dependent life****	$1,500 for each eligible dependent or $100 for each eligible child (live birth to 6 months old)

***To purchase dependent life, you must enroll for additional life (Option 1). You must list eligible dependents in Section 3.*

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5. VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

You also have the option of purchasing up to $500,000 of accidental death and dismemberment (AD&D) insurance for yourself and your eligible dependents (through age 25, if full-time students) through CPF Health Benefits Trust.

Please complete attached "Application for Personal Accident Insurance" enclosed.

I am purchasing coverage for: ☐ Myself (member) only ☐ Myself (member) + family

The amount of coverage I want is: ☐ $100,000 ☐ $200,000 ☐400,000 ☐ other $ _____ *(not less than $25,000 or more than $500,000).*

6. PROTECT YOUR INCOME (PYI)

For $28.00 per month (administrative fee included) – **Summary of Benefits:** Up to $10,000 of Monthly Income Replacement; 66.7% pay protection (see pre existing limitations); $60,000 Lump-Sum payment for Occupational Disability after 5 years of Total & Permanent Disability: No waiting period – eligible for benefits the day following put on "no-pay" status; $50,000 payment for contracting work related HIV infection; $50,000 accidental Death Benefit; $5,000 Additional Benefit if you lose your life due to an auto accident while wearing an appropriately fastened seat belt; $15,000 additional benefit for Felonious Assault; Quadriplegia Benefit - $50,000; Paraplegic Benefit $37,500; Hemiplegics Benefit $25,000; Survivor Benefit – Provides continuation of benefits to survivors for up to two- years.

(Offered by CPF Health Benefits Trust- Administrated by Harry J. Wilson Insurance Center, Inc. Benefits underwritten by National Union Fire Insurance Company of Pittsburgh, P.A. and provided by UNITED VALLEY INSURANCE AGENCY.)

I am purchasing PYI coverage ☐

7. BENEFICIARY INFORMATION (ACTIVE MEMBERS ONLY)

You must complete this information for your automatic and voluntary life and/or accidental death and dismemberment insurance to become effective. Under **Beneficiary's Name**, enter the name of a person, "my estate" or the name of an organization. You may enter combinations (e.g., one beneficiary may be a person and another may be an organization, etc.). If more than one beneficiary is designated, settlement will be made in equal shares to the beneficiary(ies) still living, unless you designate distribution percentages (percentages must add up to 100%). If no designated beneficiary survives, settlement will be made to your estate. Dependent life benefits are paid to you while living. If you have questions, contact Local 1014's insurance office.

Beneficiary's Name (Last, First, MI)	**Percent of Benefit** (Total = 100%)	**Social Security #**	**Address**	**Relationship**	**Date Of Birth**	**Daytime Phone Number**	**Effective Date** (Local 1014 Use Only)
						( )	
						( )	
						( )	

Consent of spouse (required in community property states when someone other than the spouse is named beneficiary):

Spouse's signature_____ Date_____

Witness' signature_____ Date_____

8. PLEASE READ THE FOLLOWING AND SIGN AND DATE THIS FORM

I agree that the information on this form is complete, correct and true, to the best of my knowledge and belief, and that no required information has been omitted. I understand that if I choose not to enroll myself or my dependent(s) in the Los Angeles County Fire Fighters Local 1014 Medical Plan coverage when first eligible, I will not be allowed to enroll for coverage until the next annual enrollment unless I can demonstrate a qualified change in status or special circumstance as defined by the Los Angeles County Fire Fighters Local 1014 Medical Plan Summary Plan Description. I further understand that my elections will remain in effect and cannot be revoked or changed unless they are a direct result of, and consistent with, an IRS qualified change in status or a special circumstance as defined by the Los Angeles County Fire Fighters Local 1014 Medical Plan Summary Plan Description. I understand that if I do not enroll for voluntary life and/or AD&D coverage when first eligible, or if I want to increase the amount of my insurance or add dependent coverage, I/my dependent(s) might be required to provide proof of good health for all coverage amounts.

Authorization: I authorize Local 1014 to deduct from my earnings (until further notice) my contributions for the coverage I have elected on this form.

_____ _____

Member Signature Date

For Local 1014 Use Only

Class:	Effective Date:	Start Date:	Stop Date: