

LIFELOCK MEMBERSHIP ELECTION FORM



Benefit Trust

Please print with ballpoint pen-make a copy of this application for your records. See below for instructions to submit your application.

Your Information	Name:		Email:	
	DOB:	SSN#:	Gender:	Phone #:
	Address:			
SEMI-MONTHLY RATES	Semi-monthly CAPE Member Deduction:		Benefit Elite Plan	Ultimate Plus
	<input type="radio"/> Member (18+ Years Old)		\$ 3.75	\$12.25
	<input type="radio"/> Member + Spouse/Domestic Partner		\$ 7.99	\$24.99
	<input type="radio"/> Member + Children (Up to age 26)		\$ 6.93	\$17.56
	<input type="radio"/> Member + Family		\$11.18	\$30.31

Add dependent information below if you elected dependent coverage:

Name	DOB	Gender	SSN#

ARE YOU CURRENTLY AN ACTIVE LA COUNTY EMPLOYEE: YES _____ NO _____

		DEDUCTION AGENCY NAME CALIFORNIA ASSOCIATION OF PROFESSIONAL EMPLOYEES										DEDUCTION CODE EU105			
EMPLOYEE NUMBER		DEPT. NO.		EMPLOYEE LAST NAME						FIRST NAME		MI			
DO NOT FILL IN THE SHADED AREA												NOT TO BE USED FOR COUNTY INSURANCE PLANS			
CHANGE INDIC.	DEDUCTION AMOUNT				DEDUCT %		I HEREBY AUTHORIZE THE AUDITOR OF THE COUNTY OF LOS ANGELES OR HIS AGENTS TO DEDUCT MONTHLY FROM SALARY EARNED BY ME IN ANY DEPARTMENT OR DISTRICT OF THE COUNTY OF LOS ANGELES, THE AMOUNT SHOWN HEREON AND TO PAY SAME TO: CALIFORNIA ASSOCIATION OF PROFESSIONAL EMPLOYEES IF ALL OR ANY PORTION OF THIS DEDUCTION AUTHORIZATION INCLUDES INSURANCE PREMIUMS AND/OR EMPLOYEE ORGANIZATION DUES, I ALSO AUTHORIZE THE AUDITOR TO ADJUST FROM TIME-TO-TIME THE AMOUNT OF THIS DEDUCTION AS MAY BE REQUIRED TO COMPLY WITH ADJUSTMENTS IN COUNTY SUBSIDY AMOUNTS OR IN PREMIUMS UNDER EXISTING CONTRACTS WITH SAID INSURANCE PLANS, OR TO COMPLY WITH DUES SCHEDULES DETERMINED BY SAID EMPLOYEE ORGANIZATIONS' GOVERNING BODY IN ACCORDANCE WITH SUCH ORGANIZATIONS' CONSTITUTION CHARTER, BYLAWS, OR OTHER APPLICABLE LEGAL REQUIREMENTS. THIS AUTHORIZATION CANCELS AND REPLACES ANY PREVIOUSLY SIGNED BY ME WITH THIS DEDUCTION AGENCY FOR THIS PURPOSE AND SHALL REMAIN IN EFFECT UNTIL CANCELLED BY ME BY WRITTEN NOTICE. I EXPRESSLY UNDERSTAND AND AGREE THAT THE AUDITOR, HIS AGENTS, OR THE COUNTY ACTING UNDER THIS AUTHORIZATION SHALL NOT BE LIABLE IN ANY MANNER FOR FAILURE OR DELAY IN MAKING THE DEDUCTIONS OR PAYMENTS HERE AUTHORIZED.								
		OLD	NEW		OLD	NEW									
NEW															
REPL.															
CANC.															
STOP DATE		LIMIT AMOUNT													
PAYROLL DEDUCTION AUTHORIZATION															

I authorize my employer to deduct on an after tax basis from my salary or wages the necessary premium for the coverage requested above. The signature below also verifies the accuracy of the information contained on this form. I understand that the amount of my payroll deduction, benefit amount and annual salary will not change until the next policy renewal date, and that I must stay enrolled for 12 months, or as long as I am a County employee, which ever is less. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a third degree felony. Questions? Call our dedicated customer service team at (800) 487-3092.

SIGNATURE: _____

DATE: _____

E-MAIL ADDRESS: _____

PHONE: _____

YOU CAN MAIL, FAX, OR E-MAIL THIS APPLICATION TO:

Mail to: Dexheimer-Erickson Corporation
350 S. Figueroa St., Ste. 950, Los Angeles, CA 90071

FAX to: (213) 225-5611
E-Mail to: d-e.clientservices@dex-erickson.com

