

Join CAPE today by printing and completing this Application.

Please fax your completed application to (213) 484-4963.

Make sure to list a beneficiary for your \$20,000 Life Insurance policy and please do not forget your signature at the bottom of the form.

Employer:

- LA County
- Sanitation Districts



CALIFORNIA ASSOCIATION OF PROFESSIONAL EMPLOYEES
 MARINE ENGINEER BENEFICIAL ASSOCIATION, AFL-CIO
MEMBERSHIP APPLICATION

Employee Number	Last Name	First Name	Initial	Division
	M / F			
Date of Birth	Sex	Employment Date	Dept. #	Job Title
Home Address			City	Zip Code
Business Address			Home Phone	
			Business Phone	
E-mail Address		Name of Recruiter		Employee #

I hereby request and accept membership in CAPE, the union that represents me and negotiates and concludes on my behalf any and all agreements as to wages, working hours and other conditions of work. I agree to be bound by the Bylaws of CAPE and by any contracts that may be in existence at the time of the application, or that may be negotiated by CAPE. I further agree to pay dues on a monthly basis at the rate established by the CAPE Board of Directors (currently 1% of base salary), and I authorize the County to deduct such dues from my paycheck. I understand that I may terminate my membership and dues deduction mentioned above only during contractually negotiated "withdrawal periods" as designated in my Unit's collective bargaining agreement. State and Federal regulations require the use of dues money for political activities to be optional. Check here if you do not want any of your regular monthly dues to be used for political activities.

Date _____ Signature _____
(Also, please sign payroll authorization card at the bottom of this form.)

CAPE LIFE INSURANCE BENEFICIARY DESIGNATION
 (You may change this designation at anytime by contacting the CAPE office.)

Primary Beneficiary(ies) _____ Benefit % _____ Relationship _____

Contingent Beneficiary(ies) _____ Benefit % _____ Relationship _____
 (In event of Primary Beneficiary(ies) prior death)

DO NOT DETACH

DEDUCTION AGENCY NAME	DEDUCTION CODE
CALIFORNIA ASSOCIATION OF PROFESSIONAL EMPLOYEES	416

DO NOT WRITE ABOVE THIS LINE

EMPLOYEE NUMBER	DEPT. NO.	EMPLOYEE LAST NAME	FIRST NAME

DO NOT FILL IN THE SHADED AREA		
CHANGE INDIC.	DEDUCTION AMOUNT	
	OLD	NEW
NEW <input type="checkbox"/>		
REPL <input type="checkbox"/>		
CANC <input type="checkbox"/>		

NOT TO BE USED FOR COUNTY INSURANCE PLANS

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 DEDUCTION OR PAYMENTS HERE AUTHORIZED

PAYROLL DEDUCTION AUTHORIZATION

_____ DATE _____ SIGNATURE OF EMPLOYEE _____