RELIANCE STANDARD

GROUP SHORT TERM DISABILITY ENROLLMENT FORM

Please print with ballpoint pen-make a copy of this application for your records. See the enclosed benefit summary for eligibility and enrollment rules. See below for instructions to submit your application.

All sections must be completed to ensure accurate processing.	(1) Policyholder: **CAPE BENEFIT TRUST**		(2) RSL Policy No. **VPS325878**
	(3) Date of Hire	(4) Job Title	(5) Base Annual Salary* *verified at time of claim
	(6) Full Name Last, First: Home Address:		
	(7) Social Security Number	(8) Gender	(9) Date of Birth
Choose Only One- (10) or (11)	**(10) Request for Group Insurance Coverage (Complete County deduction form below):** ☐ I request to purchase Group Disability Insurance Coverage based on **50%** of my covered earnings up to a weekly max of $1,000. This benefit is tax-free. Weekly Maximum Benefit: ______________ (See enclosed rate chart - 14 day waiting period for sickness or accident) Semi-Monthly Premium is: ______________ (See enclosed rate chart)		
	(11) Declination of Group Insurance Coverage ☐ I have been offered and have declined to purchase the Group Disability Insurance Coverage. I understand that in the event I desire such insurance at a later date: (1) I will be required to furnish evidence of insurability at my own expense; and (2) Reliance Standard Life Insurance Company (RSL) will have the right to refuse my future request.		

ARE YOU CURRENTLY AN ACTIVE LA COUNTY EMPLOYEE: YES____________NO______________

	DEDUCTION AGENCY NAME			DEDUCTION CODE
	CALIFORNIA ASSOCIATION OF PROFESSIONAL EMPLOYEES			**EU105**
EMPLOYEE NUMBER	DEPT. NO.	EMPLOYEE LAST NAME	FIRST NAME	MI

DO NOT FILL IN THE SHADED AREA					
CHANGE INDIC.	DEDUCTION AMOUNT OLD	DEDUCTION AMOUNT NEW	DEDUCT % OLD	DEDUCT % NEW	
NEW					
REPL.					
CANC.					
STOP DATE		LIMIT AMOUNT			

PAYROLL DEDUCTION AUTHORIZATION

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 DEDUCTIONS OR PAYMENTS HERE AUTHORIZED.

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, whichever 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: ______________________

DETACH THIS FORM AND YOU CAN MAIL, FAX, OR E-MAIL IT 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