LIFELOCK MEMBERSHIP ELECTION FORM

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 Essential	Benefit Premiere
	○ Member (18+ Years Old)	$ 4.25	$12.75
	○ Member +1 or More	$ 7.43	$18.06

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				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

NOT TO BE USED FOR COUNTY INSURANCE PLANS

CHANGE INDIC.	DEDUCTION AMOUNT OLD	DEDUCTION AMOUNT NEW	DEDUCT % OLD	DEDUCT % NEW
NEW				
REPL.				
CANC.				

STOP DATE	LIMIT AMOUNT		

PAYROLL DEDUCTION AUTHORIZATION

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