

**DEPUTY SHERIFF'S ASSOCIATION OF KINGS COUNTY
MEMBERSHIP APPLICATION**

APPLICANT

First Name:	Middle Name:	Last Name:
Date of Birth:	Last 4 of SSN: XXX-XX-	Gender: <i>(circle one)</i> Male Female
Address:		
City:	ZIP Code:	Home Phone:
Department: <i>(circle one)</i> Sheriff's Office D.A.'s Office		Personal Cell:
E-Mail:		Work Phone:

ADDITIONAL INFORMATION

Conditions:

- I understand that upon acceptance I will be enrolled into the Deputy Sheriff's Association of Kings County (KCDSA): _____ *(Initial)*
- I understand KCDSA currently has a formal retainer with a law firm for professional services: _____ *(Initial)*
- I understand I will be enrolled into the Peace Officers Research Association of California (PORAC): _____ *(Initial)*
- I understand I will be enrolled into PORAC Legal Defense Fund (LDF): _____ *(Initial)*
- I understand there are costs associated with the above benefits: _____ *(Initial)*
- I understand the Deputy Sheriff's Association of Kings County is authorized to collect dues through payroll deduction for which I receive benefits: _____ *(Initial)*

Optional:

- I wish to apply for Long Term Disability Insurance: Yes No *(circle one)*

BENEFICIARY FOR KCDSA DEATH BENEFITS

Name:	Relationship:
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AUTHORIZATION

I hereby make application for membership in the Deputy Sheriff's Association of Kings County and agree to abide by its regulations such as those set forth in the By-Laws.

Signature of Applicant:	Date:
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BOARD MEMBER USE ONLY

Board member receiving application:	Initial:	Date:
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Insurance & Benefits Trust of PORAC

Gold Short and Long Term Disability Plan Summary of Benefits For **Safety** Members

Plan Features

Short-Term Disability (Plan # 610007 - R)

Long-Term Disability (Policy # 649401 - A)

How Benefits are Funded	Fully self-funded and administered by the I&B Trust of PORAC.	Fully insured by Standard Insurance Company- A.M. Best rated A (excellent); Standard and Poor's rated A+ (strong). Ratings as of October 2017. Ratings include the Standard Life Insurance Company of New York.
Percentage of Wages Protected	Up to 66 2/3% of the first \$15,000 monthly Pre-Disability Earnings, reduced by Deductible Income.	66 2/3% of the first \$15,000 monthly Pre-Disability Earnings, reduced by Deductible income during the initial 12 months of LTD benefit eligibility. After 12 months of LTD benefit eligibility: Non Industrial Disabilities: 66 2/3% Industrial Disabilities: 16 2/3%
Catastrophic Disability Benefit	During the initial 12 months of Disability, the plan pays up to an additional 33 1/3% of the first \$15,000 of monthly Pre-Disability Earnings, not to exceed \$5,000.	N/A
Maximum Monthly Benefit	\$10,000 (66 2/3% of \$15,000) before reduction by Deductible Income.	\$10,000 (66 2/3% of \$15,000) before reduction by Deductible Income.
Maximum Benefit Period	12 Months	To age 65 if age 61 or younger when Disability began. Maximum Benefit Period for Disabilities that occur after age 61 will be determined by your age when Disability began.
Own Occupation Period	During the initial 12 months of Disability.	12 months following the waiting period.
Freeze of Sick Leave	After 60 Days	(Premium payments are waived while Disability Benefits are payable)
Minimum Benefit	\$200 per month for Non-Industrial Disabilities.	\$200 per month while receiving sick pay for Non-Industrial Disabilities. \$50 per month in all other circumstances
Sick Leave Integration Benefit (Non-Industrial only)	After 60 days, receive 100% of base pay through use of 50% leave time and 50% STD Benefit.	After 60 days, receive 100% of base pay through use of 50% leave time and 50% LTD Benefit.
STD Benefit Eligibility Waiting Period	Industrial Disabilities: 0 days Non-Industrial Disabilities: 0 days, if you have been unable to work for 15 days, provided that you have not had a Temporary Recovery of greater than 5 days during this period.	365 days (Premium payments are waived while Disability Benefits are payable)
LTD Waiting Period	During the first 60 days of Disability: <ul style="list-style-type: none"> You are eligible to receive up to 33 1/3% of your monthly Pre-Disability Earnings, reduced by Deductible Income. You are required to use any available personal leave pay you are eligible to receive from your Employer. 	
Musculoskeletal & Connective Tissue Disorders	No limitation	For certain conditions, benefits are limited to 12 months for each period of disability.
Mental & Nervous Disorders	No limitation	Benefits are limited to 6 months for each continuous period of disability caused or contributed to by a Mental Disorder, or as long as hospitalized.
Drug & Alcohol Use	Benefits limited to 12 months lifetime	Benefits limited to 6 months lifetime
Death Benefit	\$65,000 Death Benefit (Accidental) \$50,000 Death Benefit (Natural) (You are covered for the Death Benefit while enrolled under the STD Plan and during the first two years you continue to be disabled and receiving Disability Benefits).	\$65,000 Death Benefit (Accidental) fully insured through ReliaStar Life Insurance Company. \$50,000 Death Benefit (Natural) fully self-funded through IBT of PORAC

Monthly Contribution: \$29.70

Group Disability Application

GOLD - Group Short/Long Term Disability Program

DIRECTIONS: This form must be completed to apply for Group Disability Coverage. When Evidence of Insurability is required, that form will be provided separately. To apply for coverage (as a Member) read the notice(s) on back page of application.

Then complete all items, sign, and date below.

When finished, send original to Myers-Stevens & Toohey & Co., Inc. and keep a copy for your records

Please print clearly (black ink): Fax, Mail or Scan and E-Mail to:



Myers-Stevens & Toohey & Co., Inc. | 26101 Marguerite Parkway | Mission Viejo | CA 92692
 phone 800.827.4695 | fax 949.348.2630 | PORAC@myers-stevens.com | license #0425842

Insurance & Benefits Trust of PORAC (STD Plan 610007 - R) Standard Insurance Company (LTD Policy 649401- A)

Tell Us About Yourself:

Your Name		Sex ____ Male ____ Female	SSN
Home Address			
City		State	ZIP
Date of Birth	E-Mail Address	Home Phone	Work Phone
Full Name of Your Employer			Date Employed
Association Name		Associate Number	
Monthly Salary \$	Date of PORAC Membership	/ /	PORAC # (if available)

Please confirm you are a Safety Member by initialling the space below.

I am a: _____ Safety Member

Safety Member is an employee who is eligible to receive benefits under California Labor Code Section 4850 and safety employee benefits under the County Employees Retirement Act of 1937 or Public Employees Retirement Systems (PERS) of California, or benefits comparable thereto, with their employer at the time of Disability is incurred.

As a member in good standing of PORAC and having read the attached brochure describing the benefits. I hereby apply for coverage under my association's disability plan which is subject to the provisions of the Insurance and Benefits Trust of the Peace Officers Research Association of California Group Short Term Disability Plan Document and The Standard Long Term Disability Policy. I certify that I am working full-time and able to perform all the required duties of my occupation. Upon approval of this application, I authorize my employer to make the necessary deductions from my wages or salary to cover my contribution (if any) for the cost of this coverage.

Member's Signature _____ Date _____

DETACH FORM HERE



**PORAC Group Life Insurance
Enrollment Form**

**Reliastar Life Insurance Company
20 Washington Avenue South
Minneapolis, MN 55401-1900**

Please Print

66326-3-2		Department/Association Name		Social Security Number	
Member Name (Last, First, M.I.)			Male <input type="checkbox"/>	Birthdate (Month/Day/Year)	
			Female <input type="checkbox"/>		
Address		Apt #	City	State	Zip Code
Date Employed	Job Title		Hours Worked Each Week		For
			This Employer		(Not Incl.
			Overtime) _____		

Complete beneficiary designation for PORAC Group Life Coverages. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further beneficiary information.

Primary - Full Name	Address	Relationship	% of Benefit

Contingent - Full Name	Address	Relationship	% of Benefit

I wish to apply for insurance under the PORAC Group Life Insurance Plan (66326-6) underwritten by Reliastar Life Insurance Company, or to authorize the changes noted above. I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

X _____ Date _____

Note: Beneficiary designation is not valid unless this form is signed and dated.

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "John W. Smith, Trustee under the trust agreement dated_____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.