California Law Enforcement Association

CSLEA Long Term Disability Enhanced Individual Plan Application

Send your completed application using one of these convenient options:
Fax: (209) 223-2966 • Scan and email: accounting@clea.org
Mail: CLEA, PO Box 31, Martell, CA 95654

Last Name	First Name	M.I.	Birth Date / /	Social Sec. No.*

Mailing Address	Department	Employment Date / /

City	State	Zip Code	Phone ( )

Employment Designation*	CSLEA Member?*	E-Mail Address
☐ Safety ☐ Non-Safety	☐ Yes ☐ No	

***Information required for application to be processed. Your information will be safeguarded and not shared.**

PLEASE SELECT ONE OF THE FOLLOWING METHODS OF PAYMENT

❑ **Monthly Bank Draft** ($1.00 surcharge per transaction)

❑ **Checking** ❑ **Savings** Financial Institution ___________________________

Account # ___________________________ Routing # __________________

❑ **Credit Card** ❑ Annual ❑ Semi-Annual ($1.00 surcharge per transaction)

Type of Credit Card: ❑ Master Card ❑ Visa ❑ Discover Card

Number _________________________________ Exp. Date_________

❑ **Annual Payment - $294.00** (Make check payable to CLEA)

I hereby apply for Enhanced Individual Long Term Disability (LTD) Benefits and certify that I am an active, full-time member of CSLEA under the CalPERS Retirement system.

I agree that I shall abide by the related provisions as noted in the Plan Documents and Corporate Bylaws. Except as provided for in the "Prior Coverage Credit" provision of the Plan, I understand that any medical condition including HIV, AIDS, ARC that existed prior to my effective date of coverage or death caused by pre-existing medical conditions will not be covered until I have been enrolled in the Plan as an Active Participant for a period of sixty (60) months. Disabilities occurring after my effective date of coverage caused by psychological or emotional disorders, or their physical manifestations, or drug, alcohol, or substance abuse, will be covered after 24 months of participation unless condition is excluded because of pre-existing medical condition. Under the terms of the Plan, any dispute not resolved through the Plan's claims procedure must be resolved by binding arbitration with the American Arbitration Association. CLEA reserves the right to increase dues periodically as determined by the Board of Directors.

Special Provision:

Safety Participants not covered by Penal Code 830.2(a)-DOJ Special Agents and 830.2(e)-Fish and Wildlife Officers will have limited benefits (36 months Maximum Benefit at 66.7% of wages with a $200 Minimum Benefit and one (1) year Own Occupation Disability Plan Provision) if they suffer a disability that would normally be covered by Labor Code 3212 and its subchapters, and the disability is not determined to be job-related. A person is not eligible to enroll after he or she is 60 years of age or more.

Beneficiary information is required for the Plan Death Benefits. Contact the Plan Administrator at 1-800-832-7333 or visit www.CLEA.org to update your beneficiary choice or for additional information.

By signing below I indicate that I have read these statements including the Special Note on the Pre-Existing Conditions and the Special Provisions and acknowledge the limitations in LTD Benefits as explained. Other conditions and limitations are included in the CLEA Plan Document and Summary Plan Description.

If choosing monthly bank draft or credit card, I hereby authorize CLEA or its designated agent and the financial institution named below to initiate withdrawals from my checking/savings account or credit card as specified. This authorization will remain in effect until cancelled by me or CLEA.

Your Signature____ Date ____________________

Beneficiary____ Relationship ___________________________
(Please do not list minors)

Beneficiary Address____ Beneficiary Phone ____________________

Contingent Beneficiary _____________________________________ Relationship ___________________________
(Please do not list minors)

Contingent Beneficiary Address _______________________________ Contingent Beneficiary Phone _____________

Please do not write in this space. Office use only.

Received: ____________ Effective Date: ____________ Dept.: ________________ Cert. No.: ________________ SPD Sent: ___________