DSA GENERAL MEMBERSHIP FORM

Name:	Social Security Number:
Home Address:	Date of Birth:
City:	Body Number:
Zip Code:	Home Phone:
Job Title/Rank	Work Phone:

Statement of Understanding

I understand that as a member of the Santa Barbara County Deputy Sheriff's Association (DSA) I will receive the following benefits: 1. Legal Defense Fund, 2. Long Term Disability Insurance, 3. PORAC Membership, 4. Other association benefits.

My DSA dues, which cover the aforementioned benefits, will be paid on a biweekly basis through voluntary payroll deductions. The DSA is responsible for making payments to cover the expense of these benefits.

I may also elect to enroll in additional insurance policies offered through the DSA, such as Aflac and Colonial. These additional policies will be paid on a biweekly basis through voluntary payroll deductions. The DSA is responsible for making payments to cover the expense of these policy premiums.

In the event payroll deductions of my DSA dues and additional insurance policies (if applicable) are not made; for reasons such as, but not limited to, leave without pay, furlough, and family leave, I will be responsible for paying the biweekly amounts due directly to the DSA Insurance Chairperson. Each payment will be made within a "reasonable" amount of time.

If I choose to carry an additional insurance policy offered through the DSA and I decide I want to cancel the policy for any reason, I will immediately notify the DSA Insurance Chairperson, who will cancel the policy and the payroll deduction on my behalf. If I cancel this payroll deduction and/or insurance policy on my own without notifying the DSA Insurance Chairperson, the DSA will continue to make payments and I will be financially responsible for any and all restitution owed to the DSA.

I have received a copy of the Santa Barbara County Deputy Sheriff's Association Bylaws and I agree to all of the terms and conditions therein.

SIGNATURE: _____ DATE _____

DSA GENERAL MEMBERSHIP FORM

County of Santa Barbara
Office of the Auditor-Controller
105 E. Anapamu St., Rm 303 ● PO Box 39 ● Santa Barbara, CA 93102-0039

PAYROLL DEDUCTION FOR DEPUTY SHERIFF'S ASSOCIATION (BARGAINING UNITS: 14, 15)

Purpose : To direct Auditor Payroll to deduct the amount specified by the Deputy Sheriff's Association from employee's pay on a biweekly basis.

Instructions : Please complete and sign this form, and send to "**DEPUTY SHERIFF'S ASSOCIATION, P.O. BOX 3804 SANTA BARBARA, CA 93105"**

Employee Information

Print Name : _____ SSN or Emp ID : _____

Dept. Name : _____ Work # or Ext. : _____

Email Address : _____

Employee Selection

	TOTAL DEDUCTION PER PAY PERIOD				For Auditor Use
Dues		Start ☐	Cancel ☐		#151
COL Accident Insurance	**$** _____	Start ☐	Cancel ☐		#152
Mass General Liability Life Ins	**$** _____	Start ☐	Cancel ☐		#153
American Family Life Ins	**$** _____	Start ☐	Cancel ☐		#154
Additional Life Ins	**$** _____	Start ☐	Cancel ☐		#147
Trans-America Insurance	**$** _____	Start ☐	Cancel ☐		#186

Authorization

I authorize the Auditor Controller Payroll to deduct the amount specified by my Union/Association from my biweekly salary and to adjust the amount of deduction to comply with dues and/or fees schedules determined by the said union/association. This deduction form replaces any previous form(s) on this subject with the said union/ association. I agree that the County acting under this authorization shall not be liable in any manner for failure or delay in making the deductions or payments herein authorized.

I have read and understand the instructions. I understand that only full time employees are eligible to participate in and contribute to the Deputy Sheriff Association Dues and Insurance.

Employee signature : _____ Date : _____

For Auditor Payroll Use Only

Pay Period Posted : _____ Other Info : _____

GROUP APPLICATION

INSURANCE AND BENEFITS TRUST OF THE PEACE OFFICERS RESEARCH ASSOCIATION OF CALIFORNIA

Group Long Term Disability Program

Please Print or Type

MEMBER'S
Name_____ **SS#:**_____-_____-_____
Home
Address_____

City_____ **State**_____ **Zip**_____

Phone Number (_____)_____ **(_____)**_____
Home Work

Date of Birth _____/_____/_____ **Sex** _____**Male** _____**Female**
Month Day Year

Place of Birth_____ **Monthly Salary $**_____

Full Name of Your Employer **I am a:** ☐ **Safety Employee**
(Dept) _____ ☐ **Non-Safety Employee**

Date of PORAC Membership _____/_____/_____ **Date Employed** ____/____/____
Month Day Year Month Day Year

As a member in good standing of PORAC and having read the attached brochure describing the benefits. I hereby apply for coverage under the provisions of the Insurance and Benefits Trust of the Peace Officers Research Association of California Group Long Term Disability Plan. I certify that I am now able to perform full-time 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**_____

IMPORTANT: Be sure to complete and sign the health questions attached to this application when required. See section of brochure – "Completion of Health Questions and Approval by Standard Insurance Company Are Required If."

HOW TO APPLY:

1. Complete this application including attached health questions, if required.
2. Return the completed form to your Department/Local Association.
3. Don't send money now: Your premiums will be paid through payroll deduction (if applicable), once coverage is issued.

myers • stevens
26101 Marguerite Parkway
Mission Viejo, CA 92692-3203
(949) 348-0656 Fax (949) 348-2630
CA License #0425842

Be sure to read carefully and include your signature and date as indicated.

SHADED AREA FOR INSURANCE COMPANY USE ONLY.

Approved DATE ___/___/___	Denied DATE ___/___/___	Denied Due to Lack of Information DATE ___/___/___
_____ Medical Underwriter Signature	_____ Medical Underwriter Signature	_____ Evidence Processor Signature

HEIGHT	WEIGHT	PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS
		Name Full Mailing Address _____ Membership Number

Check "yes" or "no" for each of these questions, and give details for any "yes" answers after #10. (Attach a separate sheet if more room is required.)

	YES	NO
1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years?	☐	☐
2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years?	☐	☐
3. Are you now unable to work full time because of any physical, mental or emotional condition, injury or sickness?	☐	☐
4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medical for you for any of the following:		
*High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke?	☐	☐
*Mental condition, depression, epilepsy, or nervous system disorder?	☐	☐
*Cancer, diabetes, or nephritis?	☐	☐
*Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder?	☐	☐
*Lung, kidney, stomach, genital, urinary, or intestinal ailment?	☐	☐
*Blindness or deafness?	☐	☐
*Acquired Immune Deficiency Syndrome (AIDS0, AIDS-Related Complex (ARC), or an immune System disorder?	☐	☐
5. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years?	☐	☐
6. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, lesions, or growths?	☐	☐
7. Do you take medication for any physical, mental or emotional condition, injury, or sickness?	☐	☐
8. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness?	☐	☐
9. Are you now pregnant?	☐	☐

#	Description of Injuries, Disorders and Operations	Month/ Year	Duration	Final Result	Physicians Consulted City & State

Acknowledgement and Authorization for Release of Information. (Please read carefully.)

I represent that the statements contained herein are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, Standard's liability is limited to the return of any premium which may have been paid.

I acknowledge that I have read and received the Information Practices Notice (on the back of the form) and I have received a copy of this Medical History Statement.

To any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or any employer: I authorize you to release to Standard or its reinsurers all medical information you have about me including medical history, diagnosis, prognosis and treatment of any physical, mental or emotional condition. I understand that Standard will use the information obtained by this Authorization to determine my eligibility for group insurance coverage. I further authorize Standard to release this information to is reinsurers, MIB, and to other insurance companies to which I have applied for insurance coverage or benefits.

I understand a copy of this authorization will be provided upon request. This authorization will remain valid one year from the date below. A photocopy of this authorization shall be as valid as the original.

Upon approval of this application, I authorize my employer to make the necessary deductions from my wages or salary to cover my contribution for the cost of this insurance, underwritten by The Standard Insurance Company of Portland, Oregon.

_____ _____

Signature of Applicant Date