DSA GENERAL MEMBERSHIP FORM

| | |
|---|---|
| Full 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 _____

# 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 30012, Santa Barbara, CA 93130"**

**Employee Information**

Employee Name: _____ Employee ID : _____

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

Email Address : _____

**Employee Selection**

| | | | | For Auditor Use |
|---|---|---|---|---|
| **Union Dues** | Start ☐ | Cancel | ☐ | #151 |
| **American Family Life Ins (Aflac)** | | Cancel | ☐ | #154 |

**Authorization**

I authorize the Auditor Controller Payroll Division to deduct the amount specified by my Union from my biweekly paycheck and to adjust the amount of deduction to comply with dues and/or fees schedules as determined by the Union. This deduction form replaces any and all previous forms on file for Union and union-negotiated insurances. I agree that the County is acting under this authorization shall not be liabile 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's Association Dues and Insurances.

Employee signature : _____ Date : _____

***For Auditor Payroll Use Only***

Pay Period Posted : _____ Other Info : _____

# 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.<br>After 12 months of LTD benefit eligibility:<br>Non Industrial Disabilities: **66 2/3%**<br>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.<br>**$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**<br><br>**LTD Waiting Period** | Industrial Disabilities: **0** days<br>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.<br><u>During the first 60 days of Disability:</u><br>• You are eligible to receive up to **33 1/3%** of your monthly Pre-Disability Earnings, reduced by Deductible Income.<br>• You are required to use any available personal leave pay you are eligible to receive from your Employer. | **365** days (Premium payments are waived while Disability Benefits are payable) |
| **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)<br>**$50,000** Death Benefit (Natural)<br>(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.<br>**$50,000** Death Benefit (Natural) fully self-funded through IBT of PORAC |

## Monthly Contribution: $29.70

This is an illustration only. Refer to Plan Documents and Insurance Policy for complete details. CA License Number 0425842.
For additional assistance please contact your Myers-Stevens & Toohey & Co., Inc. representative at: 800-827-4695

# 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<br>____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<br>$ | Date of PORAC Membership<br>/ / | | 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