LACERS
LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM

360 E. Second Street, 2nd Floor
Los Angeles, CA 90012
(800) 779-8328
TDD (888) 349-3996
www.lacers.org

ELECTION TO PARTICIPATE IN FAMILY DEATH BENEFIT INSURANCE PLAN

The Family Death Benefit Insurance Plan (FDBIP or "the Plan") is a voluntary life insurance program designed to provide increased financial protection for surviving families of active LACERS members who die before retirement. Similar to the protection provided by Survivors Insurance under Social Security, the FDBIP is funded on an insurance basis with participating members and the City sharing the cost, and is in addition to other death benefits provided by LACERS. For the year beginning July 1, 2004, each participating member pays a monthly Plan premium of $3.70 and the City matches that amount. Active employees can join the Plan **after 18 months of City service**. After an **additional 18 months of paid Plan membership** Plan members are entitled to basic Plan coverage. Please refer to the Family Death Benefit Insurance Plan Information Sheet for further information. To enroll in the Plan, please complete the lower portion of this page and return this entire election form to the address above.

Family Death Benefit Insurance Plan Election

I hereby elect to participate in the Family Death Benefit Insurance Plan as provided in Section 4.1063 of the Los Angeles Administrative Code.

► *If you have 18 months or more of prior City service (including service at the Department of Water & Power) you may be qualified for immediate FDBIP coverage. If so, are you interested in purchasing all prior FDBIP time for which you may be eligible? (Check one)* ***Yes*** ☐ ***No*** ☐ *(If you answer yes, LACERS will verify your eligibility, then send you a cost letter requesting a choice of payment options.)*

I understand that I will make a contribution of $1.85 by payroll deduction for 24 pay periods during each calendar year. This contribution may be subject to change.

I understand that I may cancel my participation in the Plan at any time and that my contributions prior to the cancellation date are not refundable.

I understand that these benefits are not applicable after I retire.

I understand that in order for my family to receive benefits under the Plan, I must be a contributing Plan member for a minimum of 18 months at the time of my death.

Signature ____ Date ____________________

Print Name __________________________________ Social Security #_______/_____/________

Work Telephone Number ______________________________

For office use only		
Member's Eligible Date:	Verified by:	Date: