

## ELECTION TO PARTICIPATE IN FAMILY DEATH BENEFIT PLAN - ALL MEMBERS

The Family Death Benefit Plan (FDBP or “the Plan”) is a voluntary program designed to provide increased financial protection for surviving families of active LACERS members who die before retirement and is similar to the protection provided for Survivors under Social Security. Participating members and the City share the cost of funding the FDBP, and is an addition to other death benefits provided by LACERS. For the year beginning July 1, 2020, each participating member pays a monthly Plan premium of \$2.40 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 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 Plan Election**

I hereby elect to participate in the Family Death Benefit Plan as provided in Division 4, Chapter 10 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 FDBP coverage. If so, are you interested in purchasing all prior FDBP time for which you may be eligible? (Check one)*  
 Yes  No  *(If you answer yes, LACERS will verify your eligibility and then send you a cost letter requesting a choice of payment options.)*

I understand that I will make a contribution of \$1.20 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.

\_\_\_\_\_  
Member’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Telephone Number

For Office Use Only		
Member’s Eligible Date:	Verified by:	Date:

## **ADA NOTICE**

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.