DEPUTY SHERIFFS' ASSOCIATION OF SAN DIEGO COUNTY

MEMBERSHIP APPLICATION

MEMBERSHIP TYPE: ☐ CLASS 1 (ACTIVE SWORN) ☐ (RESERVE) ☐ (RETIRED)

NAME:			
	Last	First	Middle

HOME ADDRESS:				
	Number and Street	City	State	ZIP

HOME PH:		CELL:	
DATE OF BIRTH:		SSN:	☐ MALE ☐ FEMALE
HOME E-MAIL:			

AFFIRMATION FOR ALL MEMBERS:
I hereby make application for membership in the Deputy Sheriffs' Association of San Diego County and agree to abide by the regulations as set forth in the Articles of Incorporation and By-Laws.

ADDITIONAL AFFIRMATION FOR CLASS 1 (ACTIVE SWORN) MEMBERSHIP:
As a Class 1 member, I hereby designate the Deputy Sheriffs' Association of San Diego County to represent me on wages, hours, working conditions, and all other matters concerning my employment and to collect dues and other sums I may authorize for Association programs beneficial to me by payroll deduction.

Signature Date

ADDITIONAL INFORMATION REQUIRED FOR CLASS 1 MEMBERSHIP

DATE SWORN / GRADUATED ACADEMY:		ARJIS NO.:	
WORK LOCATION:			
If you are re-joining the association, what was your previous date of resignation?			

PLEASE CHECK CURRENT CLASSIFICATION:
☐ Deputy Sheriff ☐ Deputy Sheriff – Detentions/Courts ☐ Sheriff's Sergeant ☐ Sergeant – Detentions
☐ Sheriff's Lieutenant ☐ Lieutenant – Detentions ☐ Sheriff's Captain

Please write the name(s) of your association death benefit beneficiary below:

NAME:		RELATIONSHIP:	
NAME:		RELATIONSHIP:	

I would like to receive more information on the following member benefits and opportunities:
☐ Auto & Home Insurance ☐ Dental Insurance ☐ Vision Insurance ☐ AFLAC Insurance

FOR OFFICE USE ONLY

MEMBERSHIP NUMBER:		

COUNTY OF SAN DIEGO
WORKERS' COMPENSATION
PERSONAL PHYSICIAN PRE-DESIGNATION FORM

In the event a work-related injury, the law provides an employer medical control for the first thirty (30) days if the employee has not pre-designated a physician. After that time frame an employee may be treated by a physician or medical facility of choice within a reasonable geographic area. As an alternative to using the County's designated provider, an employee may pre-designate his or her personal physician for treatment.

To qualify as a pre-designated physician all of the following conditions must be met. The physician:

- serves as the employee's primary care physician and has previously directed the employee's medical treatment;
- retains the employee's medical records, including medical history; and
- agrees to be pre-designated.

If an employee desires to pre-designate their personal physician, the following information and signatures are required. The completed form should be forwarded to the Department of Human Resources, Workers' Compensation program at mail stop D -226 or faxed to 619.578.5740. If you have any questions, please call 619.578.5700.

It is the employees' responsibility to get the completed form to the Workers' Compensation program.

(Please Print)

Employee's Name _____

Employee Number: _____

Department: _____

Work Telephone Number _____

Date of Request _____

Employee's Signature _____

Name of Physician _____

Physician's Address _____

_____

I meet the personal physician conditions noted above.

Physician's Signature/Date: _____

Revised June 2004

California Law Enforcement Association

A Non-Profit Mutual Benefit Association

Post Office Box 31, Martell, CA 95654-0031

(209) 223-3971 • (800) 832-7333 • Fax (209) 223-2966

www.clea.org

Deputy Sheriffs' Association of San Diego County Group Long Term Disability

FEATURES / BENEFITS

Monthly Cost	**$19.50** per month, level cost payroll deduction
Percentage Of Wages Protected*	**85%** of wages Non-Industrial Disability **70%** of wages Industrial Disability (100% of wages for Catastrophic Disabilities for up to 30 months) (No Workers' Compensation Permanent Disability offsets) Maximum Benefit of **$9,500** per month, ***tax-free***
Waiting Period	**30 Calendar days** – If less than 60 calendar days of personal leave, you may receive 70% of wages after 30 calendar days. Otherwise, 60 calendar days.
Benefit Period	**Lifetime:** Sickness, Accident and Pregnancy (Industrial Disability and Non-Industrial Disabilities)
Freeze of Personal Leave Option	After **60** calendar days
Personal Leave Integration Benefit	After **60** calendar days, you may use personal leave and receive a supplemental benefit from the Plan up to the Maximum Percentage or use 100% personal leave and receive $1,000 per month ($100 per month for Industrial or Disputed Workers' Comp.)
Cost of Living Benefit (COLA)	**4%** compounded per year (years 3-8) thereafter, **CPI** increase to age 65 and then continued **lifetime benefits**
Return To Work Incentive Benefit	$1,000 per month for Non-Industrial Catastrophic Total Disability if a Participant returns to gainful employment.
Waiver of Payment	Waiver of Payment after no-pay status
Benefits Payable During Challenged Workers' Compensation Cases	After **60** calendar days – **70%** of wages to a Maximum Benefit of **$9,500** per month (Repayable only if settled in your favor)
Minimum Monthly Benefit	**$1,000** per month – paid in addition to personal leave after 60 calendar days. ($100 per month Industrial or Disputed Workers' Compensation claims.)
Death Benefit	**$65,000** Death Benefit on- or off-duty natural, accidental or terminal illness ($15,000 initial benefit then $1,000 per month for 50 months) $10,000 for suicide ($2,000 first 2 Years in Plan) *(Benefits may be payable within 24 hours of notification)*
Survivorship Benefit	**Six (6)** months additional benefits to dependent beneficiary
Pre-Existing Medical Condition Coverage	If you enroll during your initial enrollment period, all pre-existing medical conditions will be covered once you have been in the Plan for twenty-four (24)/ forty-eight (48)** months, unless you are eligible for the *Prior Coverage Credit* – otherwise, pre-existing medical conditions will not be covered.
Ownership of Plan	Owned, operated and managed by its Participants through a representative Board of Directors *(non-profit California Corporation since 1985)*

* Maximum percentages reflect amount payable after completion of (a) waiting period, (b) freeze of personal leave option, or (c) personal leave integration. Offsetting Benefit/Income Amounts are applied to reduce amount from the Plan

** The Death Benefit for suicide is limited to $2,000 for the first 24 months of participation in the Plan.

*** Forty-eight months for Death Benefits, and for HIV, AIDS, and ARC.

The California Law Enforcement Association (Safety Personnel) Long Term Disability Plan was established pursuant to the California Department of Insurance, Insurance Code Sections 11400 – 11407 (Peace Officers Benefit and Relief Association) by CLEA, a police officers benefit and relief association. CLEA is a non-profit corporation exempt from tax under Internal Revenue Code Section 501(c)(9). The Plan, CLEA and the Trust, are annually audited by independent certified public accountants in conformity with generally accepted accounting principles.

10-15 This is a highlight page only – certain exceptions & limitations apply. See the Summary Plan Description or the complete Plan Document provisions for a more complete description of coverage. CA Insurance Lic. #0544968

Application for California Law Enforcement Association (CLEA) Long-Term Disability Group Coverage

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

Mailing Address	Employment Date	Name of Employer
	/ /	

City	State	Zip Code	Phone
			( )

Current Job Title	E-Mail Address

Special Note: Pre-Existing Conditions are eligible for coverage after 24 months of participation if you enroll during the one-time Initial Enrollment Period with your Association or Department, or during the first 60 days of your sworn employment. Otherwise, Pre-Existing Conditions or conditions caused or contributed to by Pre-Existing conditions, are excluded from coverage, except as provided for in the "Prior Coverage Credit." Disabilities caused by psychological or emotional disorders, or their physical manifestations, or drug, alcohol, or substance abuse, will be covered after 24 months of participation. Other conditions and limitations related to Pre-Existing Conditions are included in the CLEA Plan Document and Summary Plan Description. Please contact the Plan Administrator for additional information or to request a copy of the Plan.

Please initial here to indicate that you have read this special note: _____

I hereby apply for Group Long-Term Disability (LTD) Plan Benefits offered through my employee Association or Department, and agree that I shall abide by the stated provisions as noted in the Plan Documents and Corporate By-laws. Payroll deduction is authorized if applicable. Except as provided for in the "Prior Coverage Credit" provision of the Plan, I understand that any medical condition that existed prior to my effective date of coverage will not be covered until I have been enrolled in the Plan as an Active Member for a period of twenty-four (24) months. Additionally, HIV, AIDS, ARC and death caused by pre-existing medical conditions will not be covered for forty-eight (48) months. 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. Please see the Plan Document for additional information.

Special Provision: Participants not covered by Penal Code 830.1 and 830.2(a) will have limited benefits (36 months Maximum Benefit at 66 2/3% of wages 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.

By signing below you are indicating that you have read these statements and that you are working a full-time schedule as a safety or sworn employee.

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.

Please respond to the following questions.
(If this section is incomplete, enrollment will be delayed until complete.)

In your department or association are you:

1. A safety employee with a safety retirement? ❑ Yes ❑ No
2. Considered a full-time employee? ❑ Yes ❑ No
3. Eligible for L.C. 4850 pay, IDL, or its equivalent? ❑ Yes ❑ No
4. Currently at work on a regular schedule? ❑ Yes ❑ No

If you answered "No" to any of the questions above, please contact the Plan Administrators at 1-800-832-7333 to discuss eligibility.

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

Received: _____ Effective Date: _____

Dept.: _____

Cert. No.: _____ SPD Sent: _____

Your Signature _____ Date _____

Beneficiary _____ Relationship _____
(Please do not list minors)

Contingent Beneficiary _____ Relationship _____
(Please do not list minors)

CLEA • PO Box 31 • Martell • California • 95654 • www.CLEA.org

Why Do I Need Long Term Care?

- The average annual cost of convalescent care is **over $69,000.**
- In **20 years**, the average annual cost is expected to **exceed $180,000.**
- The average lifetime expense to care for an **Alzheimer's patient** is **$290,000.**
- **3 out of 5** people over age 65 will require a **minimum of 3 years Long Term Care assistance.**
- Recent statistics show that **1 in 7 people** now living in nursing facilities are **under age 65.**
- **1 in 5 patients** in Long Term Care over age 65 can expect to spend more than **5 years** in a **nursing facility.**
- As a member of a Public Pension Plan, Law Enforcement and Fire Service personnel would **never qualify** for government assistance through **Medicaid** or **Medicare.** Your monthly retirement allowance and other assets would need to be extinguished to qualify.

NPFBA Long Term Care Plan Benefits:

- Lifetime Coverage
- Nursing Home Care
- Residential Care
- Home Health Care
- 5% Compounded Inflation Protection (Limited to 15 Years)
- 25 Year Paid-Up Plan
- Respite Care
- Death Benefit
- 60-day Elimination Period
- Waiver of Payment

Comparable Monthly Costs for $150/Day Plan*

	NPFBA	CalPERS[2]	John Hancock	Genworth
Age 35	**$39**	$106	$219	$233
Age 45	**$63**	$170	$293	$262
Age 55	**$122**	$248	$364	$346
Age 60	**$208**	$305	$434	$401
Payment Schedule	**25-45 Years[1]**	Lifetime	Lifetime	Lifetime
Elimination Period	**60-days**	90-days	60-days	90-days

The NPFBA Long Term Care Plan was developed by Law Enforcement and Fire Service personnel to protect those who protect others. The Plan is managed by experienced Law Enforcement and Fire Service personnel dedicated to providing the very best benefits at the lowest rate.

NPFBA™

NATIONAL PEACE OFFICERS AND FIRE FIGHTERS BENEFIT ASSOCIATION™

1-877-582-0003

WWW.NPFBA.ORG

CA Lic. #0544968

*This chart is provided for illustration only. NPFBA payment periods may vary depending on age at enrollment. Additional payment options may be available. Please refer to Plan Document for specific details. Rates as of Sept. 2010 and may not reflect current information available. For current rates, refer to NPFBA approved and published rate at time of application. [1]Payment period may depend on age at enrollment. [2]CalPERS LTC New Enrollment suspended until further notice.

Long Term Care Benefit Comparison

Benefits	NPFBA	CalPERS
Lifetime Coverage	✓	Available
Nursing Home Care $130/day or $150/day	✓	Other Options Available
Residential Care (Assisted Living) 70% of $130 Plan ($91/day) 70% of $150 Plan ($105/day)	✓	✓
Home Health Care 50% of $130 Plan ($65/day) 50% of $150 Plan ($75/day)	✓	Other Options Available
5% Compounded Inflation Protection*	✓	✓
25-Year Paid-Up Plan	✓	Lifetime Premiums
Death Benefit is the Return of Payments up to $5,000 To age 70: Up to $5,000 Ages 71–75: Up to $2,500 Thereafter: $0	✓	Prorated Return of Payments Based on Percentage 75 or Older: $0
Respite Care –Adult Sitting 15 days max per year	✓	✓
60-Day Elimination Period**	✓	90-Day
Waiver of Payment	✓	✓

**Limited to 15 Years. **90-Day Elimination Period if rated Standard.*

The Power of 5% Compounded Inflation Protection

Your benefit increases each year after your first calendar year in the Plan and grows annually thereafter up to year 15.

Future Benefit Projections

(Daily Benefits have been rounded to the nearest whole number.)

$150 Plan

Year In Plan	Daily Benefit	Monthly	Yearly
Current	$150	$4,563	$54,750
At 5	$182	$5,536	$66,430
At 10	$233	$7,087	$85,045
At 15	$297	$9,034	$108,405

$130 Plan

Year In Plan	Daily Benefit	Monthly	Yearly
Current	$130	$3,954	$47,450
At 5	$158	$4,806	$57,670
At 10	$202	$6,144	$73,730
At 15	$257	$7,817	$93,805

(Limited to 15 years.)

Monthly benefit equals daily benefit multiplied by 365 days divided by 12 months.

Deputy Sheriffs' Association of San Diego County
Life Insurance Option 2

Active Members:
Life & AD&D Benefit: *$100,000*

Spouse:
Life & AD&D Benefit: *$7,500*

Children:
Life & AD&D Benefit: *$5,000*

$10.84 per pay period

****If you enroll within 60 days of the date of becoming a member of the Deputy Sheriffs' Association you do not need to complete any medical questions; you will be a late applicant and subject to Evidence of Insurability if you elect to participate in this plan after your 60 day eligibility period.**

AD&D ENHANCEMENTS:

Seat Belt Benefit: This benefit provides the lesser of $50,000 or the amount of AD&D insurance benefit payable for loss of life that occurs in an automobile accident if the insured is properly wearing a seat belt. The driver must have a current, valid driver's license.

Air Bag Benefit: This benefit provides the lesser of $20,000 or the amount of AD&D insurance benefit payable for loss of life that occurs in an automobile accident for which a Seat Belt Benefit is payable, if the automobile is equipped with a properly maintained air bag system. The insured must be seated in the driver's or front passenger seat, and the driver must have a current, valid driver's license.

Child Care Benefit: This benefit provides the lesser of $5,000 or the total child care expenses incurred by the insured's spouse within 12 months after the insured's death. This benefit will pay the insured's spouse for child care provided by a licensed daycare provider, who is not a family member, for dependents under the age of 18. The child care expenses must occur because the spouse must work or obtain training for work to increase earnings.

BeneficiaryAssist®

We understand a loss can leave you feeling overwhelmed. Times are difficult when the unthinkable happens. In addition to grief, you may have financial and legal worries you're not prepared to face alone. That's why we're here to make sure getting support is as simple as possible. The Hartford's1 Beneficiary Assist program through ComPsych® helps you cope with the emotional, financial, and legal issues that can arise after a loss. The program is offered at no cost to beneficiaries of group life or accident policies. Simply call the toll-free number, 1-800-411-7239, 24 hours a day, 7 days a week to access loss counseling, financial and legal professionals on a confidential basis.

Travel Assistance – A Simple Way For You to *Navigate Life's Journeys.*

TRAVEL SERVICE FROM THE HARTFORD[1] – DEALING WITH THE BUMPS IN LIFE JUST GOT EASIER.

You're on the road and things take an unexpected turn – an emergency occurs. You need help plain and simple. Well now, assistance is simply a phone call away for employees covered under a group policy through The Hartford. Toll-free emergency assistance is available to you, your spouse, and your dependents[2] 24 hours a day, 7 days a week when traveling 100 miles or more from your primary home (national or international travel) for 90 days or less. The Hartford's Travel Assistance Program is provided by Worldwide Assistance Services, Inc., a leader in the travel assistance industry. Please keep the wallet-size ID card with important contact information handy for easy access when planning for or while on a trip.

TRAVEL SERVICES OFFERED – SIMPLICITY FROM THE WORD GO.

The Hartford's Travel Assistance Program provides three kinds of services for your business or vacation travels – Pre-Trip Information, Emergency Medical Assistance and Emergency Personal Services. Of course, all our travel services are simple to take advantage of from start to finish. The program offers funds up to $150,000 to cover services provided.[4] A service qualifies for payment or reimbursement only if Worldwide Assistance Services, Inc. was contacted at the time of service and arranged and/or pre-approved it.

PRE-TRIP INFORMATION – LIFE'S A TRIP. PREPARING FOR IT SHOULD BE SIMPLE.

Planning a trip can often be more complex than you think, so the Travel Assistance Program includes a wide range of helpful informational services before you leave home or the office, including:

- Visa, Passport, Inoculation and Immunization Requirements
- International "Hot Spots"
- Travel Advisories
- Foreign Exchange Rates
- Embassy and Consular Referrals

EMERGENCY MEDICAL ASSISTANCE

When you have a medical emergency, the Travel Assistance Program pays for assistance as described below, *but you are personally responsible for paying your medical/hospital expenses.*

- **Medical Referrals –** Refers you to physicians, dentists and medical facilities worldwide.
- **Medical Monitoring –** During the course of a medical emergency, professional case managers, including physicians and nurses, will monitor your level of care and determine if further intervention, medical transportation or possibly repatriation is needed.
- **Medical Evacuation –** Transportation to the closest medical facility that can provide an appropriate level of care will be arranged and paid for if medically necessary.
- **Repatriation –** Transportation home for further medical treatment will be arranged and paid for if medically necessary.
- **Traveling Companion Assistance –** If your traveling companion's previously made travel arrangements are lost due to your hospitalization, new arrangements will be made and funded.
- **Dependent Children Assistance –** If, due to your hospitalization, your dependent children are left unattended, travel arrangements will be made and funded for their return home with a qualified escort if necessary.
- **Visit by a Family Member or Friend –** If you are traveling alone and are hospitalized for at least 7 consecutive days or are in critical condition, travel arrangements will be made and funded for a family member or friend to visit if that service is deemed medically necessary.
- **Emergency Medical Payments –** Advances funds to cover on-site medical expenses, upon satisfactory guarantee of reimbursement.
- **Return of Mortal Remains –** The proper return of remains for burial will be arranged and paid for in the event of death while traveling.
- **Replacement of Medication and Eyeglasses –** Your prescription or eyeglasses will be replaced if lost, stolen, or used up, subject to local law, whenever possible. *Payment for the prescription medication, eyeglasses or any shipping expense is your personal responsibility*.

THE HARTFORD

DEPUTY SHERIFF'S ASSOC. OF SAN DIEGO CO.
Supplemental Life Insurance Enrollment Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Employer Name: Deputy Sheriff's Association of San Diego		Policy Number: 764514
Street Address: 13881 Danielson Street		
City: Poway	State: CA	Zip: 92064-6891
Please check all that apply: New Enrollment: ☐	Over G.I.: ☐	Change: ☐
Employee First Name:	MI:	Last Name:
Street Address:		
City:	State:	Zip Code:
Day Time Phone:	Evening Phone:	
Social Security Number:	Date of Birth:	Email Address:
Occupation:	Date of Hire:	Annual Salary: $
Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No		

Basic Employee and Dependent Life Insurance – Spouse and Dependent Children

You have the opportunity to enroll in Deputy Sheriff's Assoc. of San Diego Co.'s Basic Dependent Life Insurance plan for yourself, Spouse and eligible Dependent Children. This plan provides you with $100,000 Basic Life coverage, $7,500 Basic Life coverage for your Spouse, and $5,000 Basic Life coverage for each Dependent Child. To be eligible for this plan, you must enroll within 31 days of initial eligibility, or new hire status. Enrollment in this plan is optional, with a pay period cost of $10.84.

☐ I elect to **enroll** in the Basic Life Insurance plan for $10.84/per pay period.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company

Employee First Name:_____ Last Name_____ Social Security Number:_____

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:

- Mary J. Doe, Wife (not Mrs. John Doe).

Contingent:

- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

Beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Employee Confirmation

I have been given the opportunity to enroll in Deputy Sheriff's Assoc. of San Diego Co.'s Supplemental Life Insurance plans. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and understand my request for coverage may be denied.

I understand that coverages available to me are in accordance with the provisions of the contract between The Hartford and Deputy Sheriff's Assoc. of San Diego Co., and that I will not be insured for coverages not included in that contract.

I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis. I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force.

Signature: _____ **Date:** _____

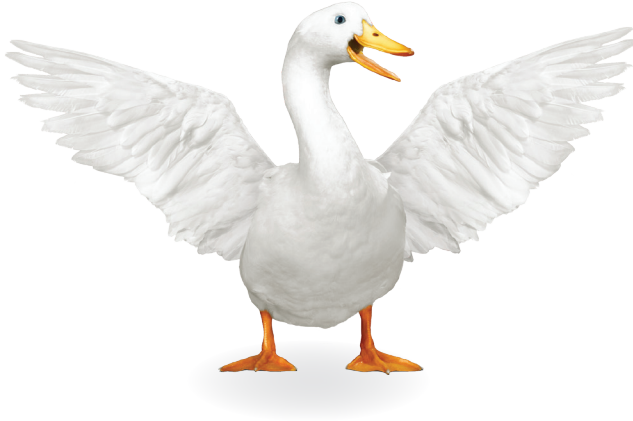
Aflac is an extra measure of financial protection.

When you're sick or hurt,
Aflac pays cash benefits directly
to you, unless otherwise assigned,
to help you and your family
with unexpected expenses.

For more information about policy benefits, limitations, and exclusions, please call your Aflac insurance agent:

Jill Krenkler
CA License No. 0D97588
5924 Balfour Ct. Suite 100
Carlsbad, CA 92008
(760) 473-8023
jill_krenkler@us.aflac.com

DSA Members can now apply for Aflac online. Please visit www.aflac.com/dsasd for more information and to apply for coverage.



Aflac®

We've got you under our wing.®

DENTAL BENEFITS

Members residing in California have the option to select a Dental HMO or Dental PPO plan. Members living outside of California may enroll in the Dental PPO plan. To both maximize and manage your PPO and HMO Dental benefits, log on to: **www.myuhcdental.com** to locate a provider, view benefits, order ID cards and review your claims history. A summary of the Dental benefit plan design options are listed below. Please review your summary plan booklet, available at www.dsasd.org, for a more detailed description.

UnitedHealthcare Dental PPO

Benefit Schedule	In-Network	Out-of-Network
Individual Deductible	$0	$25
Family Deductible	$0	$50
Calendar Year Maximum	$1,000	
Preventive Services		
Routine Oral Exam Cleaning Fluoride Treatment Sealant X-rays	100%	100%
Basic Services		
Fillings General Anesthesia Oral Surgery Endodontics Periodontics	90%	80% After Deductible
Major Services		
Crowns Removable & Fixed Bridges Dentures	60%	50% After Deductible
Waiting Period for New Enrollees	12 months for Major Services	

UnitedHealthcare Dental Customer Service:

(877) 816-3596
Monday – Friday: 5:00 am to 8:00 pm PST

UnitedHealthcare Dental HMO

Preventive Care	
Routine oral exams	$0
Cleaning	$0
Sealant – per tooth (child under age 18)	$0
Bite-wing and full-mouth x-rays	$0
Fluoride treatment (child)	$0
Fluoride treatment (adult)	$0
Restorative	
Amalgam filling	$0
Resin-based composite (anterior)	$0-$20
Resin-based composite (Posterior)	$25-$45
Crown – Single Restorations	$90-$215
Other Restorative Services	$0-$125
Endodontics	
Anterior (excluding final restoration)	$45
Bicuspid (excluding final restoration)	$75
Molar (excluding final restoration)	$115
Periodontics	
Gingivectomy or gingivoplasty	$50
Osseous surgery	$155-$225
Periodontal scaling and root planing	$15-$25
Prosthetic (dentures/partials)	
Complete denture – maxillary	$150
Complete denture – mandibular	$150
Reline complete maxillary	$0
Oral Surgery	
Surgical removal of erupted tooth	$15
Removal of impacted tooth	$25-$90
Deep sedation/general anesthesia	$155 first 30 mins
Orthodontics	
Treatment transitional dentition	$1,895
Treatment adult dentition	$1,895

VISION BENEFITS

The Vision program is offered through United Healthcare. United Healthcare's Vision program provides affordable, quality vision care nationwide. United's network includes over 25,000 private practice and retail chain providers, the most notable chains being Wal-Mart, Sam's Club and Costco (exam visits only). You can locate a United Healthcare Vision provider by calling the 24 hour toll-free provider locator at (800) 839-3242 or by logging on to: **www.myuhcvision.com**.

With United, you are able to visit any provider you choose but, you maximize your savings when you visit a network provider. A summary of the Vision benefits is listed here. Please refer to the summary plan booklet, available at www.dsasd.org, for a complete description of your benefits.

United Healthcare Vision Plan		
	In-Network	**Out-of-Network**
Exams	Covered in Full	$45
Lenses		
Single Vision	Covered in Full	Up to $45
Bifocal	Covered in Full	Up to $65
Trifocal	Covered in Full	Up to $85
Lenticular	Covered in Full	Up to $85
Frame Allowance (Retail)	Up to $130	Up to $47
Frame Allowance (Private Practice)	Up to $130	Up to $47
Elective Contact Lenses*	Up to $125	Up to $125
Necessary Contact Lenses*	Covered in Full	Up to $250
*Contact lenses in lieu of lens and frame benefits		
Frequency		
Exams	Once every 12 months	
Frames	Once every 12 months	
Lenses	Once every 12 months	

United Healthcare Vision Contact

Customer Service: (800) 638-3120
Monday – Friday: 5:00 am to 8:00 pm PST,
Saturday: 6:00 am to 3:30 pm PST
Provider Locator: (800) 839-3242
Website: www.myuhcvision.com

DEPUTY SHERIFFS' ASSOCIATION OF SAN DIEGO COUNTY

13881 Danielson Street, Poway, CA 92064

BENEFITS APPLICATION

GENERAL INFORMATION

Name (Last, First, MI)	Social Security Number	Gender	Date of Birth (MM/DD/YY)	Date of Hire (MM/DD/YY)	DSA Member ID Number
	/ /	☐M ☐F			
Classification	**Event**		**Effective Date of Coverage**	**Date of Retirement**	**Home Phone #**
☐Active Member ☐Retired Member	☐Open Enrollment ☐Cancellation ☐Changes				( )

Residence Mailing Address	Apt./Unit #	City	State	Zip	E-Mail Address

DENTAL AND VISION ENROLLMENT

Choose from the following dental and vision plans. You may select one dental plan and the vision plan. (☑ the box(es) that apply)	VISION			HMO DENTAL			PPO DENTAL		
	☑	Per Pay Period	Monthly	☑	Per Pay Period	Monthly	☑	Per Pay Period	Monthly
Member Only	☐	$4.02	$8.03	☐	$6.47	$12.93	☐	$20.29	$40.58
Member + One	☐	$6.26	$12.51	☐	$12.28	$24.56	☐	$39.65	$79.29
Member + Two or More	☐	$10.30	$20.59	☐	$18.69	$37.38	☐	$64.80	$129.59

MEMBER/DEPENDENT INFORMATION

Name (Last, First, MI)	Social Security No.	Relationship	Gender	Date of Birth (MM/DD/YY)	Indicate Which Coverage Applies to Each Person			Dental Provider Name & City (DHMO Only)	Existing Patient	Dental Provider Group # (DHMO)
		Member			☐VISION	☐ DHMO	☐ DPPO		☐Yes ☐No	
		☐ Spouse ☐ Dom. Part.	☐M ☐F		☐VISION	☐ DHMO	☐ DPPO		☐Yes ☐No	
		Child	☐M ☐F		☐VISION	☐ DHMO	☐ DPPO		☐Yes ☐No	
		Child	☐M ☐F		☐VISION	☐ DHMO	☐ DPPO		☐Yes ☐No	
		Child	☐M ☐F		☐VISION	☐ DHMO	☐ DPPO		☐Yes ☐No	
		Child	☐M ☐F		☐VISION	☐ DHMO	☐ DPPO		☐Yes ☐No	
		Child	☐M ☐F		☐VISION	☐ DHMO	☐ DPPO		☐Yes ☐No	

BENEFIT COORDINATION/OTHER INSURANCE CARRIER INFORMATION

Do you or your dependents have any other dental or vision insurance? If "Yes", complete the following information:

Benefit	Insurance Company	Policy #	Who is covered under this other policy?
☐ Dental ☐ Vision			
☐ Dental ☐ Vision			
☐ Dental ☐ Vision			

SIGNATURE

I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED AND HEREBY AUTHORIZE MY EMPLOYER/ASSOCIATION TO MAKE THE NECESSARY DEDUCTION(S) FROM MY WAGE/SALARY TO PAY MY PORTION OF THE PREMIUM.

ARBITRATION DISCLOSURE: I agree that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and United HealthCare and PacifiCare of California or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

(Date) (Signature)

revised 8/28/17

CHIROPRACTIC PLAN

Chiropractic care is available through the Administrative Health Fund to all members of the Deputy Sheriffs' Association of San Diego County, their spouse/domestic partner, child (18 years or under), or step child (18 years or under and living in the deputies home).

Active Members **$10 per payday**
Retired Members **$21.60 per payday**

Rates per Visit

	Initial Exam	1 visit per week	2nd visit of week	3rd visit of week
Member	$40.00	$20.00	$10.00	$5.00
Spouse/Domestic Partner	$30.00	$10.00	$10.00	$10.00
Child	$30.00	$5.00	$5.00	$5.00

This plan will become effective immediately upon receipt of payroll deduction form.

MASSAGE

Massage will be available in the following offices at $40 per hour and $25 per half hour at the following offices:

Dr. Cincotta (619) 444-3191
Dr. Flores & Dr. Lund (619) 275-2214
IPSB (858) 490-1154 (One hour sessions only)

To enroll in the plan or for more information, please call the DSA at (858) 486-9009 or visit www.adhealthfund.com

Administrative Heath Fund (619) 656-7304

PLAN CHIROPRACTORS

Dr. Danny Bachova
2691 Via Mercado, Ste 15
La Mesa, CA 91941
(619) 444-3191
www.sdchiropractic.net

Anthony Becerra D.C.
25136 Hancock Ave. Ste C
Murrieta, CA 92562
(951) 461-4617
Email: purechiropractic@verizon.net
www.purechiro4you.com

Dr. Gary Bretow
1274 Morena Blvd
San Diego, CA 92110
(619) 276-7575
www.bretowchiropractic.com

Dr. Lance H. Cohen
8781 Cuyamaca Street, Ste J
Santee, CA 92071
(619) 449-0593

Dr. Ryan Curda
4747 Mission Blvd, Ste 1
San Diego, CA 92109
(858) 866-3345

Dr. Kevin Dette
123 Main St.
Vista, CA 92084
(760) 643-9191
www.pacificfamilychiropractic.com

Dr. Alison Flores
Dr. Dan Jurgens
9855 Erma Road, Ste 104
San Diego, CA 92131
(858) 547-8913
www.jurgenschiropractic.com

Dr. Hillari Hamilton
2999 Mission Blvd.
San Diego, CA 92109
(858) 539-7227
www.mbchiropractic.com

Dr. Matt Hubbard
4344 Convoy St., Ste. K
San Diego, CA 92111
(858) 279-7300
www.healthyimpressions.com

Dr. Kerry Keiser
543 Orange Avenue
Coronado, CA 92118
(619) 437-4900
www.discoverwellnesscoronado.com

Dr. Mark Krause
2345 Fletcher Pkwy
El Cajon, CA
(619) 460-4465

Dr. Scott Lund
1524 Encinitas Blvd.
Encinitas, CA 92024
(760) 753-4300
www.lundchiropractic.com

Dr. Bob Mason
5181 Baltimore Dr.
La Mesa, CA 91941
(619) 589-7869
www.adhealthplan.com

Dr. Gerald Palmes
2425 Camino Del Rio South #100
San Diego, CA 92108
(619) 758-5820

Dr. Earl Shaw
27536 Ynez Rd., Suite F19
Temecula, CA 92591
(951) 695-1176

Dr. Jason Deitch
www.discoverwellnesscenter.com
fees: FREE Personalized Wellness Coaching

Deputy Sheriffs' Association
Authorization and Payment Plan

I, _____, wish to take part in the Chiropractic plan, endorsed by the Deputy Sheriffs' Association of San Diego County, and I authorize the Deputy Sheriffs' Association of San Diego County to institute a payroll deduction in the amount of $10.00 per pay period, beginning with the pay period following the date of this form. Retirees who wish to take part in the Chiropractic plan may pay a yearly administration fee of $260.00 directly to Administrative Health Fund or $21.67 per month through DSA deduction as approved by SDCERA.

Deputy:_____
Print full name (first, middle and last)

Street Address:_____

City and Zip Code:_____

Home Phone:(_____)_____ **Work Phone:(_____)**_____

Employee ID Number:_____

Person to contact in case of emergency:_____
(Not living at same address) *Name and relationship*

Address:_____ **Phone:(_____)**_____

Please check one: [ ] Active [ ] Affiliate [ ] Reserve
[ ] Retired [ ] DSA Staff

The above authorization will entitle each deputy who is currently a dues paying member of the Deputy Sheriffs' Association of San Diego County; their spouse/domestic partner (as defined in the M.O.A.), minor children, or minor stepchildren living in the deputy's home to chiropractic care and massage at specific locations. This authorization shall remain in effect for a period of no less than ONE YEAR, unless just cause is presented to ADMINISTRATIVE HEALTH FUND by the DSA member. This authorization will be discontinued only upon receipt of a written request by the member, with a reasonable amount of time to act on said request.

The Deputy Sheriffs' Association of San Diego County is held harmless for any fees due but not collected.

It is the member's responsibility to contact ADMINISTRATIVE HEALTH FUND within 10 days if any of the above information changes.

******My signature below indicates, under penalty of perjury, that the above information is true and correct, and that I have read, understand and accept all terms of this agreement.

Member Signature:_____**Date:**_____

ADMINISTRATIVE HEALTH FUND
P. O. Box 212408 Chula Vista, CA 91921
Phone: (619) 656-7304
Fax: (619) 934-2061
Email: adhealthfund@yahoo.com

DEPUTY SHERIFFS'
METLAW HYATT LEGAL PLAN

ADVANTAGES OF METLAW'S HYATT LEGAL PLAN

Broad Coverage: MetLaw's plan provides coverage for many frequently needed personal legal matters. They encourage usage so you receive maximum return on your benefit dollars.

Ease of Use: You have direct and immediate access to your choice of local attorneys, both in- and out-of-network.

Office Visits for an Unlimited # of Matters: Office visits are encouraged to develop solid relationships with your attorneys, resulting in better service and higher satisfaction.

Attorney Management Expertise: MetLaw has well-developed expertise for the management and delivery of a legal plan. They have an entire department – managed by attorneys – dedicated to supervising the attorney network and ensuring quality control.

Extraordinary Customer Service: The call center is staffed for peak-time usage. During business hours, phones are answered "live" in five seconds by professional Representatives who help maximize the value of the legal plan. MetLaw operates a full-service website with an easy "Attorney Locator Search Engine" and many helpful resources.

Attorney Code of Excellence: Plan attorneys are required to participate in MetLaw's Code of Excellence to help ensure that participants will receive the highest quality of service.

Multilingual Services: Both English and Spanish-speaking representatives are available. Most of MetLaw's participating law firms have multilingual capabilities.

MetLaw is a legal services plan that provides legal representation for you, your spouse and dependents at a cost of $8.25 per pay period - a cost that won't break your budget and is paid through the convenience of automatic payroll deductions.

If you are currently enrolled in the PrePaid legal plan, you may continue those legal benefits or opt to enroll in the MetLaw plan. All new enrollees will be enrolled in the MetLaw Hyatt Legal plan.

To enroll in the new plan, complete the Enrollment Form on the opposite side of this document. The DSA will automatically deduct $8.25 per payroll for the MetLaw Plan. Once you enroll, you must remain in the Plan for the entire Plan year. You will automatically be re-enrolled in this benefit each year unless you elect to discontinue your participation during the annual Open Enrollment.

Finding an affordably priced lawyer to represent you when you have trouble with creditors, buy or sell your home, or even prepare your will can be a challenge. Now you have a resource at your fingertips for important, everyday legal services. What's more, you'll also have someone to turn to for unexpected legal matters. With MetLaw, you can receive legal advice and fully covered legal services for a wide range of personal legal matters, including: court appearances, document review and preparation, debt collection defense, wills, family matters and real estate matters.

MetLaw's services are available through a network of more than 10,000 participating attorneys nationwide, including, on average, 30 attorneys in SD County and 10 within the city of San Diego. MetLaw's Plan Attorneys have met stringent selection criteria and have an average of 22 years or more of legal experience. Plan Attorney assistance includes: covered legal services, consultations on the telephone, in-person consultations, document preparation and representation for many frequently needed personal legal matters. Plus, if you stay within the network, covered legal services are provided with no additional attorney fees. Of course, you also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule. It's completely your choice!

When you face a situation that you think has legal implications, simply pick up the phone. A knowledgeable Client Service Representative will be available to assist you with locating a Plan Attorney near your home or workplace. Many Plan Attorneys are available to meet with you on weekdays, evenings and even Saturdays. You can also access MetLaw's e-panel of attorneys 24 hours a day, 7 days a week.

Please contact the DSA should you have additional questions about the MetLaw Plan.

<u>Announcing an improvement to the Portability feature</u>

The period of portability for the legal plan has increased to 30 months. Members can port the legal plan if they are enrolled in the plan and their enrollment terminates.

For more information visit Hyatt Legal Plans online at:
www.legalplans.com
click on "Thinking about Enrolling?"
and enter password: MetLaw
or call 1-800-821-6400

Smart. Simple. Affordable.

Hyatt Legal Plans

A MetLife Company

MetLaw®
Enrollment Form for
Deputy Sheriffs' Association Of San Diego County

Name (please print): _____

Social Security Number: ___ - ___ - ___

Home Zip Code: _____

❑ Yes, I wish to enroll in MetLaw® and understand there will be a payroll deduction of $8.25 per pay period for this benefit. I understand this election will remain in effect for the entire benefit plan year, as long as I maintain payroll deduction status or until I am no longer an eligible member of the DSA. I authorize the DSA to take the appropriate after-tax payroll deductions needed to maintain this program.

_____ _____

Signature Date

Return this form to the Deputy Sheriffs' Association.