California Law Enforcement Association

AOCDS/FOP Lodge #18 Long Term Disability

Enhanced Individual Plan Application & Payroll Deduction Form

Send your completed application using one of these convenient options:
Scan and email: accounting@caladmin.com
Mail: CLEA, PO Box 31, Martell, CA 95654

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

Mailing Address	Employment Date
	/ /

City	State	Zip Code	Phone
			( )

Employment Designation	Department	E-Mail Address
☐ Sworn	AOCDS/FOP Lodge #18	

I hereby apply for Enhanced Individual Long Term Disability (LTD) Benefits and certify that I am an active, full-time Sworn member of AOCDS/FOP Lodge #18 (active membership required) under a Public Safety Retirement system.

I agree that I shall abide by the related provisions as noted in the Plan Documents and Corporate Bylaws. I understand that any medical condition including HIV, AIDS, ARC that existed prior to my effective date of coverage or death caused by pre-existing medical conditions will not be covered until I have been enrolled in the Plan as an Active Participant for a period of sixty (60) months. Disabilities occurring after my effective date of coverage caused by psychological or emotional disorders, or their physical manifestations, or drug, alcohol, or substance abuse, will be covered after 24 months of participation unless condition is excluded because of pre-existing medical condition. 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. CLEA reserves the right to increase dues periodically as determined by the Board of Directors.

Special Provision:

Sworn Participants not covered by Penal Code 830.1, 830.2(a), and 830.2(e) 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. A person is not eligible to enroll after he or she is 60 years of age or more.

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.

By signing below I indicate that I have read these statements including the Special Note on the Pre-Existing Conditions and the Special Provisions and acknowledge the limitations in LTD Benefits as explained. Other conditions and limitations are included in the CLEA Plan Document and Summary Plan Description.

I hereby authorize the deduction from my salaries and wages of the monthly cost plus any fees for payroll deduction, now or in the future, for CLEA Long Term Disability Coverage. This authorization will remain in effect until cancelled by me or CLEA.

Your Signature _____ Date _____

Beneficiary _____ Relationship _____
(Please do not list minors)

Beneficiary Address _____ Beneficary Phone _____

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

Contingent Beneficiary Address _____ Contingent Beneficary Phone _____

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

Received: _____ Effective Date: _____ Dept.: _____ Cert. No.: _____ SPD Sent: _____