Retired Employees of Los Angeles County Membership Application & Supplemental Benefits Enrollment Form

For Office Use, Only
Received
Effective date

STEP 1: To join RELAC please complete.

Last Name	First Name	Last 4 digits of Social Security #
Address		
City	State	Zip

Male/Female	Date of Birth	Telephone ( )	E-mail Address

Select Your Membership Type.

☐ Retiree Only ($2.50 a month)	☐ Retiree & Spouse / Partner ($3.50 a month)	Spouse / Partner Name	Spouse / Partner Date of Birth

County Dept. Retired from	Retirement Date

☐ Check here to receive periodic RELAC e-mails and notices concerning topics of importance to you. ☐ Check here to receive RELAC newsletter by e-mails only.

How did you hear about RELAC? If referred by a RELAC member, please provide their name so we may thank them.

I authorize LACERA to deduct from my retirement check: (1) My monthly dues and pay that amount to RELAC: (2) If applicable, my voluntary insurance premiums and pay that amount to their respective insurance administrator. I understand that there is a minimum one-year commitment to the dental and vision plans and I acknowledge that I have read the Disclaimer in the benefit booklet.

Sign Here ➡ ______________________________ **Date**

STEP 2: To enroll in the voluntary benefit plans, please select the coverages that are right for you.

Supplemental Dental

☐ Member

☐ Member + Spouse/Domestic Partner or Child

☐ Member + Family

Vision

☐ Member

☐ Member + Spouse / Domestic Partner or Child

☐ Member + Family

Legal Shield

☐ Member + Family

☐ Add 24/7 Coverage

Personal Accident Identity Theft Shield & Secure Travel

☐ Member

☐ Member + Family

Benefit Amount: $______________________

Beneficiary: ___________________________

Relationship: __________________________

☐ Standard Plan
Receive a $3 discount when purchased *with Legal Shield*

☐ Premium Plan
Receive a $5 discount when Purchased with Legal Shield

Life Insurance

For a quote, please answer all the of following. A representative will contact you with a quote.

Your Height: ______________________ Your Weight: ______________________

Amount of Life Insurance (circle amount): $100,00 $250,00 $500,000 Other: $____________

Term / Length of Coverage (circle length): 10 Years 15 Years 20 Years

Have you ever had / been diagnosed with: ☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐ Depression ☐ Stroke ☐ High Cholesterol

Are you Taking any Prescriptions (not vitamins / supplements)? If so, what are they: ____

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Car, Home, Renters, Pet, Travel, Emergency Assistance Plus, & Amplifon Hearing
For Information on enrolling in any of these optional supplemental insurance benefits, please consult the benefits booklet or call the plan administrator, Pacific Group Agencies, at (800) 511-9065.

STEP 3: If selecting spouse / domestic partner / family coverage, provide their information.

Spouse	Date of Birth	Last 4 digits of Social Security #
Child Name (s)	**Date of Birth**	**Last 4 digits of Social Security #**

Updated 4/5/17

Please mail this completed form in the enclosed postage-paid envelope to:
RELAC, 1000 South Fremont Ave. #15 Alhambra, CA 91803
If you have any questions regarding RELAC or your membership, please call (800)537-3522