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Allow Us to Introduce Ourselves

Understanding Your Life Insurance Plan

The Los Angeles Unified School District Plan Benefits

We're Here to Help

Please enroll within 60 days of eligibility using the enrollment form in the center of this booklet. Based on the amount of coverage you choose, you may also need to complete a Statement of Health.

MetLife®

Dear LAUSD Employee:

In thinking about your financial future, ask yourself this question: ***If something were to happen to me, could my family continue their current lifestyle?***

Your family relies on you and your income to ensure their way of life. But would they be able to meet their financial obligations if something were to happen to you? MetLife offers you insurance options that can help protect your family.

Group Life Insurance – because employer-paid coverage may not be enough. Help bring your coverage up to the level your family deserves with group life insurance from MetLife. With its wide range of coverage and affordable group rates, it's a smart way to gain peace of mind.

It's easy to choose coverage to help protect your family. Here's all you do:

- Review the enclosed plan benefit guide. Find the level of coverage you want, and select the option that works for you.
- Complete and mail the enrollment form. If you are unsure of what coverage amount to choose, visit MetLife at **www.metlifeiseasier.net** for a benefit calculator. It's easy.
- Be sure to act during your eligibility period which begins the first day of the month following the date you enter your eligible class.

Your premium will be paid through convenient payroll deductions. It's just one more way this program can help make protecting your family easier for you.

Sincerely,

MetLife

As a reminder, like most group insurance policies, MetLife group policies contain certain exclusions, limitations, exceptions, reductions, waiting periods and terms for keeping them in force. Please contact MetLife for details about costs and coverage.
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LAUSD Plan Benefits

Explore the coverage that makes it easy to give yourself and your loved ones more security today…and in the future.

Basic Life Insurance Coverage

Your employer provides you with Basic Life insurance coverage in the amount of $20,000.

Optional Supplemental Life Insurance Coverage Options

For You	½ X to 5X times your basic annual earnings to a maximum of $500,000
For Your Spouse/ Domestic Partner	• $ 5,000 • $10,000 • Multiples of $25,000 (To the lesser of $200,000 or 50% of the total amount of the employee's life insurance, including basic life)
For Your Dependent Children*	**Option 1** • Under 6 months - $500 • 6 months and older - $5,000 **Option 2** • Under 6 months - $1,000 • 6 months and older - $10,000

*Child(ren)'s Eligibility: Dependent children from live birth to under age 21 or under age 25, if a child is unmarried and a full-time student, are eligible for coverage.

Monthly Costs for Optional Supplemental Life Insurance

You have the option to purchase Optional Supplemental Life Insurance. Listed below are your monthly rates as well as those for your spouse/domestic partner (based on your age and the amount of coverage you want). Rates to cover your child(ren) are also shown.

Age	Your Monthly Cost Per $1,000 of Coverage	Spouse/Domestic Partner's Monthly Cost Per $1,000 of Coverage based on spouse/domestic partner's age
Under 25	$0.025	$0.028
25 - 29	$0.026	$0.029
30 – 34	$0.038	$0.044
35 – 39	$0.045	$0.051
40 – 44	$0.063	$0.073
45 – 49	$0.094	$0.109
50 – 54	$0.143	$0.167
55 – 59	$0.245	$0.284
60 – 64	$0.356	$0.414
65 – 69	$0.551	$0.648
70 +	$0.860	$1.005

Cost for your Child(ren)†	$**0.042 / $1,000**

† Covers all eligible children

How to calculate your premium

Step 1: Multiply your annual earnings by the option selected (.5x – 5x annual earnings)

Step 2: Increase that amount to the next highest $1,000 (if not already a multiple of $1,000)

Step 3: Use the table below to calculate your premium based on the amount of life insurance you will need.

(For Example: An employee's annual earnings are $33,250. The employee selects the 3x option (3x his/her annual earnings). $33,250 x 3 = $99,750. Increase $99,750 to the next highest $1,000 = $100,000)

Example: $100,000 Optional Supplemental Life Insurance Coverage

	Example	Your Calculation
1. Enter the rate from the table (example age 36)	$0.045	$ ______
2. Enter the amount of insurance in thousands of dollars (Example: for $100,000 of coverage enter $100)	100	_______
3. Monthly premium (1) x (2)	$4.50*	$ _______

* This sample employee's monthly premium would be $4.50, deducted 12 times per calendar year.

Repeat the three easy steps above to determine the cost for each coverage selected.

Features

This insurance offering from your employer and MetLife comes with a variety of added features that can provide assistance to you and your family members today and during a difficult time.

Accelerated Benefits Option

For access to funds during a difficult time

You can receive up to 50% of your Optional Supplemental Life insurance proceeds to a maximum of $250,000 in the event that you become terminally ill and are diagnosed with less than 6 months to live. This can go a long way toward helping your family meet medical and other related expenses at this difficult time. The Accelerated Benefit Option is also available to your spouse/domestic partner insured under a Dependent Life plan (25% of Dependent Life insurance to a maximum of $50,000). This option is not available for dependent child coverage.

Conversion

For those who wish to have more permanent coverage

You can generally convert your Group Term Life insurance benefits to an **Individual Whole Life**, **Universal Life, or Variable Universal Life** insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or a change in your employee class. Conversion is available on all Group Life insurance coverages. Please note that conversion is **not** available on AD&D coverage. If you experience an event that makes you eligible to convert your coverage, you can speak with a MetLife representative by calling: 1-877-275-6387. Please contact your plan administrator for more information.

Total Control Account®

For immediate access to death proceeds

The Total Control Account® settlement option provides your loved ones with a safe and convenient way to manage the proceeds of a life [or accident policy] for claim payments of $5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. They'll have the convenience of immediate access to any or all of their proceeds, through an interest bearing account with unlimited check-writing privileges. The Total Control Account gives beneficiaries time to decide what to do with their proceeds, which can be very helpful to them during a difficult time.

What's Not Covered?

Like most insurance plans, this plan has exclusions. For instance, Optional Supplemental and Dependent Life Insurance do not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota or Colorado) of an increase in coverage.

Please note that a reduction schedule may apply. Please see your plan administrator or certificate for specific details.

Accidental Death & Dismemberment (AD&D) coverage complements your Optional Supplemental Life insurance coverage and helps protect you 24 hours a day, 365 days a year.

Accidental Death & Dismemberment Coverage Options

This valuable coverage provides benefits beyond your life insurance for severe accidents or loss of life on or off the job — while commuting, traveling by public or private transportation and during business trips. MetLife's AD&D insurance pays you benefits if you suffer an accident that results in paralysis or the loss of a limb, speech, hearing or sight, or brain damage or coma. If you suffer a fatal accident, benefits will be paid to your beneficiary.

Coverage Amounts for You

Your AD&D coverage is automatic if you choose to enroll in Optional Supplemental Life insurance and is equal to your Optional Supplemental Life Insurance coverage amount.

Coverage Amounts for Your Spouse/Domestic Partner

AD&D coverage for your spouse/domestic partner is automatic if you choose to enroll your spouse/domestic partner in Dependent Life insurance and is equal to your spouse/domestic partner's Dependent Life Insurance coverage amount.

Monthly Cost for Accidental Death & Dismemberment (AD&D) Insurance

Coverage	Monthly Cost Per $1,000 of Coverage
Employee AD&D	$0.014
Dependent Spouse/Domestic Partner AD&D	$0.014

Note: Costs for any coverages you select will be automatically payroll deducted.

Covered Losses

This AD&D insurance pays benefits for covered losses that are the result of an accidental injury or loss of life. The full amount of AD&D coverage you select is called the "Full Amount" and is equal to the benefit payable for the loss of life. Benefits for other losses are payable as a predetermined percentage of the Full Amount, and will be listed in the Table of Covered Losses in the certificate. Such losses include loss of limbs, sight, speech and hearing, various forms of paralysis, brain damage and coma. The maximum amount payable for all Covered Losses sustained in any one accident is capped at 100% of the Full Amount.

Standard Additional Benefits Include

Some of the standard additional benefits included in your coverage that may increase the amounts payable to you and/or defray additional expenses that result from accidental injury or loss of life are:

- **Air Bag Benefit**
- **Seat Belt Benefit**
- **Common Carrier Benefit**
- **Child Care Center Benefit**
- **Child Education Benefit**
- **Spouse Education Benefit**
- **Hospitalization Benefit**

What Is Not Covered?

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

Additional Coverage Information

How To Apply**

Complete your enrollment form and return it today! Be sure to indicate your Beneficiary. You may enroll for life insurance coverage quickly and securely online using the "MyBenefits" website from MetLife. It's easy to use. Just go to www.metlife/mybenefits.com. Act now during your eligibility period.

** Coverage will either be approved by MetLife based upon its underwriting rules and your answers or you will be asked to submit a Statement of Health to complete your application for coverage.

For Employee Coverage

Enrollment in this Optional Supplemental Life plan is available without providing a Statement of Health form as long as:

- Your enrollment takes place within 60 days from the date you become eligible for benefits. Your eligibility period begins the 1st of the month following your date of hire.
- You are enrolling for coverage equal to/less than 5X times your basic annual earnings or $500,000.

If you do not meet all of the conditions stated above, you will need to provide additional medical information by completing a Statement of Health form.

For Dependent Coverage*

Your spouse/domestic partner and dependent children also do not need to provide a Statement of Health form as long as they are not home or hospital confined, not receiving disability payments and

- The enrollment takes place within 60 days from the date you become eligible for benefits. Your eligibility period begins the 1st of the month following your date of hire.
- Your spouse/domestic partner is enrolling for coverage equal to/less than $50,000 and your child(ren) is enrolling for coverage equal to/less than $10,000.

*A domestic partner affidavit may be required for those partners not registered with a government agency where such registration is available.

Who Can Be A Designated Beneficiary?

You can select any beneficiary other than your employer, and you may change your beneficiary at any time. You can also designate more than one beneficiary.

About Your Coverage Effective Date

You must be "Actively at Work" on the date your coverage becomes effective, and your spouse/domestic partner and eligible child(ren) must be performing their Normal Activities when coverage becomes effective. Coverage will become effective on the first of the month following the receipt of your completed enrollment form for all requests that do not require additional medical information. Requests for amounts that require additional medical information and are not approved by the date listed above will not be effective until the first of the month following approval from MetLife or the date that Actively at Work and Normal Activities requirements are met.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and The Los Angeles Unified School District and are subject to each state's laws and availability. Specific details regarding these provisions can be found in the booklet certificate.

Life and AD&D coverage[s] are provided under a group insurance policy (Policy Form GPNP99) issued to your employer by MetLife. Life and AD&D coverage[s] under your employer's plan terminates when your employment ceases or when your Life and AD&D contributions cease, or upon termination of the group contract. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

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MetLife®
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT FORM FOR LOS ANGELES UNIFIED SCHOOL DISTRICT

SECTION TO BE COMPLETED BY METLIFE

Name of Employer	Group Customer #	Report #	Sub Division	Branch
Los Angeles Unified School District	138772	139250		

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security No.	☐ Male ☐ Female
Address Street City State Zip Code	☐ Hourly Paid ☐ Salaried	☐ Full-Time ☐ Part-Time
Date of Birth (Mo./Day/Yr.)	E-mail Address	Phone No.(include area code)

Reason for Enrollment: ☐ New Coverage ☐ New Hire/First Time Eligible ☐ Late Enrollee **(Statement of Health Required)**
☐ Change in Coverage Amount Requested ☐ Change in Enrollment other than coverage amount
☐ Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) ____________________

COVERAGE REQUEST DATA:
I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.
I request the following coverage:
Employee Coverage
☒ Basic Life (Employer Paid)
☐ Supplemental/Optional Life and Supplemental/Optional AD&D
You may elect from .5 to 5 times your Basic Annual Earnings up to a maximum of $500,000.
☐ .5x ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x Basic Annual Earnings
Dependent Spouse/Domestic Partner Coverage
☐ Dependent Spouse/Domestic Partner Life* and Dependent Spouse/Domestic Partner AD&D
☐ $5,000 ☐ $10,000 ☐ You may elect a multiple of $25,000 up to a maximum of the lesser of $200,000 or 50% of your total amount of Basic and Supplemental/Optional Life combined. **Note:** Amounts exceeding $50,000 require a Statement of Health form.
Amount Requested: $______________
Dependent Child Coverage
☐ Dependent Child Life* ☐ $5,000 ☐ $10,000
*Amounts will be subject to state limits, if applicable.

If applying for Dependent coverage (Spouse/Domestic Partner or Child), complete the following:
For Domestic Partner coverage, you must complete and attach a Domestic Partner Declaration or have registered as domestic partners or members of a civil union with a government agency or office where such registration is available. Check the applicable box:
☐ My Domestic Partner Declaration is attached.
☐ My Domestic Partner and I are registered as domestic partners or members of a civil union as stated above.

Number of dependents (including spouse/domestic partner) _____

Name of Spouse/Domestic Partner (Last, First, MI)	Date of Birth	Sex (M/F)	
____________	____________	______	
Name(s) of Child(ren) (Last, First, MI)	**Date of Birth**	**Sex (M/F)**	**Is child a full-time student?**
____________	____________	______	☐ Yes
____________	____________	______	☐ Yes
____________	____________	______	☐ Yes
____________	____________	______	☐ Yes

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ADM

Please Retain a Copy of the Fully-Completed Form for Your Records and Return the Original to MetLife in the Enclosed Envelope or to MetLife Recordkeeping Center, P.O. Box 6169, Utica, NY 13504-6169
If You Have Any Questions, Call The MetLife Benefits Line At 1-866-492-6983
(Continued on Following Page)

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee **declares** that he or she is actively at work on the date of this enrollment form and, for purposes of any contributory life insurance, that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of enrollment. In addition if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

For the Accelerated Benefits Option

Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. Receipt of accelerated benefits may affect eligibility for public assistance and an interest and expense charge may be deducted from the accelerated payment.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if life coverage is not elected, or if the maximum coverage is not elected, evidence of insurability satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York **[only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

Florida: **Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

Massachusetts: **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.**

New Jersey: **Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

Oklahoma: **Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

Kansas, Oregon, and Vermont: **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.**

Puerto Rico: **Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.**

Virginia and Washington: **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

All other states:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be crime and may subject such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)

The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. The Employee understands that he or she has the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

Signature(s): The employee must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

______________________________	______________________________	______________________________
Employee Signature	Print Name	Date Signed (Mo./Day/Yr.)