San Joaquin County Health Benefits Enrollment Form 2023 – 2024
Cafeteria Allowance Employees of Units: A (Executive), B (Senior Management), C (Middle Management), D (Confidential), J (Sheriff's Management), L (Sheriff Sergeants) and O (Exempt)

Reason for Enrollment F: ☐ Open Enrollment ☐ New Hire ☐ Qualifying Life Event: _____ (Describe)

For HR staff use only
Effective Date_____

All required documents must be received before this form is processed.
For any questions or to submit this form, contact Human Resources Employee Benefits Office at (209) 468-9987
Email: employeebenefits@sjgov.org. Fax: (209) 468-9734. Mailing address: 44 North San Joaquin Street Suite 330, Stockton, CA 95202

Employee Personal Information			
First Name, Middle Initial, Last Name:		Employee ID#:	
Street Address:	City:	State:	Zip Code:
Date of Birth:	Social Security Number:		
Best Contact Phone Number:	☐Mobile ☐Home		☐Male ☐Female
Email Address:			

Medical Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Medical Plan Options	**Coverage Level**	**Bi-Weekly Rates**	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
☐Select Exclusive Plan ☐Select Plan ☐Premier Plan ☐Sutter Health Plus HMO ☐Kaiser Permanente HMO ☐Sutter Health Plus – High Deductible Health Plan (HDHP) ☐Kaiser Permanente HMO – High Deductible Health Plan (HDHP) ☐Opt-Out of Medical ☐ No Changes	☐Employee Only ☐Employee + One ☐Employee + Family	Select Exclusive	$729.27	$1458.56	$2041.98
		Select Plan	$729.27	$1458.56	$2041.98
		Premier Plan	$790.51	$1581.02	$2213.42
		Sutter Health Plus HMO	$408.45	$816.95	$1156.03
		Kaiser HMO	$395.78	$791.56	$1120.06
		Sutter Health Plus HDHP	$307.10	$614.20	$869.10
		Kaiser HDHP	$305.38	$610.76	$864.22

-Employee's Primary Care Physician (PCP) code for Sutter Health Plus (required):
-Go to www.sutterhealthplus.org/provider-search to find a PCP or one will be auto-assigned to you)

Dental Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Dental Plan Options	**Coverage Level**	**Bi-Weekly Rates**	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
☐Delta Dental (Standard) ☐Delta Dental (Core) ☐Delta Dental (Buy Up) ☐United Healthcare (UHC) Dental ☐Opt-Out of Dental ☐ No Changes	☐Employee Only ☐Employee + One ☐Employee + Family	Delta Dental (Standard)	$9.70	$18.91	$31.74
		Delta Dental (Core)	$9.41	$18.35	$30.79
		Delta Dental (Buy Up)	$10.22	$19.93	$33.44
		UHC Dental	$11.22	$21.33	$30.26

Your dental office for UHC Dental (required):

Vision Plan Option

Vision Plan	**Coverage Level**	**Bi-Weekly Rates**	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
☐VSP (Standard) ☐VSP (Buy Up) ☐Opt-Out of Vision ☐ No Changes	☐Employee Only ☐Employee + One ☐Employee + Family	VSP (Standard)	$2.34	$4.70	$8.41
		VSP (Buy Up)	$4.14	$8.30	$14.87

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SAN JOAQUIN COUNTY
Greatness grows here.

Only for High Deductible Health Plans: Health Savings Account (Optional)

The County will contribute $700 annually (divided by 26 pay periods) towards an employee's Health Savings Account (HSA) who elects a High Deductible Health Plan (HDHP) at the employee only coverage level. The County will contribute $1,400 annually (divided by 26 pay periods) towards an employee's HSA who elects a HDHP at the employee + one or employee + family coverage level. Employees have the option to contribute the difference between the annual maximum and what the County is contributing on a pre-tax basis. This plan is similar to the Flexible Spending Account as you are able to pay for qualifying health expenses. For more information on this plan, call (833) 232-4673 or email voyasupport@voya.benstrat.com

Enter the annual election for the plan you desire. These deductions cannot be used to pay for insurance premiums. Your annual amount will be divided between the remaining number of pay periods in the calendar year you are electing coverage for.

Indicate the election change by checking the appropriate box below.

☐ Cancel Future Contributions to the HSA	
☐ Begin Contributions (First HSA Contribution this year)	$ _____ Optional Annual Employee Contributions to the HSA
☐ Change Contributions	$ _____ Optional Annual Employee Contributions to the HSA

The IRS has established annual limits that can be contributed to a Health Savings Account in 2023, which are $3,850 for single coverage and $7,750 for 2-Party or Family coverage (including the County's Contribution of $700 for employee only or $1,400 for employee + one/employee + family).

IMPORTANT:

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA Eligible." **IRS guidelines define an HSA Eligible individual as a person who:**

- **is covered under a HSA-qualified high deductible health plan (HDHP), and**
- **has "no other health coverage" (except what is permitted by the IRS), and**
- **is not enrolled in Medicare, and**
- **cannot be claimed as a dependent on someone else's tax return.**

By law, you are not eligible for HSA contributions if you:

- are enrolled in Medicare* (Part A, Part B, Medicare Advantage Plans, Part D, and Medigap/Medicare Supplemental Insurance),
- are covered by another health care plan that is not a qualified high deductible health plan (HDHP),
- can be claimed as a dependent on someone else's tax return,
- are covered by a non-HDHP such as Medicaid, TRICARE or TRICARE for Life, or
- are enrolled in a general purpose Health Care Flexible Spending Account or Healthcare Reimbursement Account (or covered by a spouse's FSA or HRA).

*With respect to being enrolled in Medicare, if you are enrolling in Medicare after attaining age 65, **HSA contributions generally should be discontinued at least six (6) months prior to filing for Medicare benefits**, because Medicare enrollment (called Medicare entitlement) can occur retroactively if you apply after you attain age 65. In such case, if you do not stop HSA contributions in a timely fashion, i.e., the six (6) months (or the months between turning age 65 and the date of application, if shorter) before you apply for Social Security (applying for Social Security is a first step toward Medicare coverage), you may have made an excess contribution and incur a tax penalty.

Information about Health Savings Account Contributions and Prorating the Maximum Yearly Contribution: If you aren't certain you'll be enrolled in a HDHP during the entire next tax year, you can contribute a prorated amount for the months you're actually eligible in the current tax year. To do this, divide the yearly allowable maximum contribution by 12, then multiply the result by the number of months you're enrolled in a HDHP during that tax year.

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your HDHP. If you are enrolled in the HDHP as of December 1, you are not required to prorate your contributions to your health savings account and can make the full year's contribution to your HSA account. However, if you base an entire tax year's contribution on your status on December 1 (and you were not HSA eligible for that entire year) and you cease to be an eligible individual before the end of the following year, any funding of the HSA over the prorated amount for the months of actual eligibility in the prior year is considered an excess health savings account contribution and the excess amount is subject to a penalty and income tax.

A few states including California may not conform their state tax laws with federal tax laws and contributions to the HSA may be taxed under these state laws. It is advisable to discuss with your tax advisor about joining a HDHP with HSA. Remember, **it is your responsibility to assure that you are an "HSA eligible" individual while contributions are made to your HSA.**

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I understand that in order for the County of San Joaquin to contribute to a health savings account (HSA) on my behalf, I must meet all of the following conditions for HSA eligibility:

- **I am covered under the County's Kaiser or Sutter Health Plus HSA-Qualified High Deductible Health Plan (HDHP), and**
- **I have "no other health coverage" (except what is permitted by the IRS), and**
- **I am not entitled to Medicare, and**
- **I cannot be claimed as a dependent on someone else's tax return.**

By signing below, I certify that all of the above statements are true. I agree to promptly notify the County of San Joaquin Human Resources Employee Benefits Office in writing if I cease to meet these conditions. I understand that the County will make contributions to my HSA only on the basis of my certifications, and that HSA contributions are subject to certain limits under federal tax law. **I further acknowledge that employee contributions are taken out of my pay check on a pre-tax basis, and that a monthly administrative fee (currently $1.15 per month) will be deducted from my HSA account. Additional fees also apply if I utilize VOYA's optional investment account options within my HSA account.**

Signature:_____ Date_____

Section 125 – Flexible Spending Accounts

If you have elected to enroll in either of the High Deductible Health Plan options, you are ineligible to enroll in the Medical Flexible Spending Account. You may elect the Health Savings Account in lieu of the Medical Flexible Spending Account listed above.

Enter the annual election for the plans you desire. These deductions cannot be used to pay for insurance premiums. Your annual amount will be divided between the remaining number of pay periods in the fiscal year you are electing coverage for. (The months with 3 paychecks, only 2 paychecks have deductions.) ***New Hires can enroll, but on a prorated amount.**

Plan Options

Medical Spending Account
(Elect up to $3,050* for 2023 – 2024 annually) $_____ annually **or** $_____ bi-weekly amount deduction

Dependent Day Care Account
(Elect up to $5,000 for 2023 – 2024 annually) $_____ annually

☐ I acknowledge that I have received a copy of the **Rules of Participation** and understand and agree to the terms and conditions of participation in the Flexible Spending Account(s), including those of the Flexible Spending Account Card.

Eligible Dependent Coverage

Check the box for the health services you wish to enroll your eligible dependents. You, as the employee, must be enrolled in the plan if you want your dependent(s) enrolled. If your dependents are enrolled, the plan selection(s) must be the same as the employee.

Required Documentation:
Social Security Number for all, Marriage Certificate (spouse), Birth Certificate (child),Certificate of Partnership (registered domestic partner), court paperwork (adopted child/legal guardianship)

Dependent(s) Name (spouse and/or children)	Relation-ship	Date of Birth	Social Security Number (required)	Medical	Dental	Vision	Primary Care Physician (PCP)

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Other Medical Coverage:
Is your spouse or any of your eligible dependents covered by another group medical plan, including San Joaquin County coverage, MediCal, or Medicare?
☐Yes. Name and Address of Other Medical Coverage_____
☐No. I certify that my spouse and/or dependents are not covered by any other medical coverage.

Kaiser Foundation Health Plan Arbitration Agreement
Please read and sign if you are electing the Kaiser plan (required).

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with Employee Retirement Income Security Act regarding certain benefit related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not be lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full Arbitration provision is contained in the Evidence of Coverage.

Employee Signature **Date**

Sutter Health Plus Plan Arbitration Agreement
Please read and sign if you are electing the Sutter Health Plus plan (required).

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and *EOC*, upon completion and execution of this enrollment form.

Binding Arbitration
Sutter Health Plus (SHP) handles/resolves member disputes through grievance, appeal and independent medical review processes. In the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes. As a condition of your membership in SHP, you agree that any and all disputes between yourself (including any heirs or assigns) and SHP, including 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 small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and SHP, including any heirs or assigns 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. I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and *EOC*.

Employee Signature **Date**

Qualifying Life Events
If you have a qualifying life event, you must provide proof within 60 days of the event. If you obtain a new dependent (through marriage, birth, adoption, registered domestic partnership, legal guardianship) or if you or your dependents lose medical, dental, and/or vision coverage, you must request enrollment in the County's plans within 60 days of the date of the event. If you do not request enrollment within 60 days, you or your dependent must wait until the next County Open Enrollment period before you can enroll and/or make changes. It is also the employee's responsibility to delete a spouse or dependent from coverage within 60 days of an event that makes the dependent ineligible for benefits (such as divorce or over-age child).

By signing below, I acknowledge that deductions are taken out of my pay check on a pre-tax basis. I must provide all dependent verification documentation within 60 days from my date of hire or qualifying life event. Rates are negotiated through my bargaining unit and approved by the Board of Supervisors. All dependents enrolled must be eligible. I understand that falsification of information by me will allow my employer to recover payments made, cancel my coverage, refuse payment of claims, and may include discipline.

Signature: _____ **Date:** _____

Please do not forget to sign here!

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE ENROLLMENT

ReliaStar Life Insurance Company, Minneapolis, MN
Telephone: 800-955-7736
A member of the Voya® family of companies

PLAN INFORMATION section to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. **All** new Life or Disability Income coverage or **any** increases in Life or Disability Income coverage will require evidence of insurability if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

PLAN INFORMATION

Employer/Plan Sponsor Name Public Risk Innovation, Solutions and Management (PRISM) Effective Date of Coverage or Change _____
Group/Plan Number 316407 Account Number/Location **039 - County of San Joaquin**
Class/Occupation _____
Date of Hire _____ Annual Salary $_____ Employment Status: ☐ Active Full-Time ☐ Active Part-Time ☐ Retired
This change is due to *(Check all that apply.)*:
☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount ☐ Late Entrant [1] ☐ Other _____
[1] *A late entrant is an individual who is first enrolling after the initial available opportunity.*

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Employee ID Number _____ Work Phone (_____)_____ Home Phone (_____)_____
Address _____ City _____ State _____ ZIP _____

EMPLOYEE LIFE / AD&D INSURANCE

Basic Life / AD&D Insurance Election

☑ Employee Only—Elect Coverage *(Note: Basic Life and Basic AD&D insurance is employer provided.)*

Supplemental Life / AD&D Insurance

Guaranteed Issue (GI) Limit = $100,000. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. Total supplemental life coverage up to $200,000 is available if you complete an Evidence of Insurability form subject to approval by the insurance company.

Supplemental Life / AD&D Insurance Election

☐ I currently have supplemental life coverage of: $_____.
☐ I am applying for additional supplemental life coverage of: $_____. *($25,000 increments)*
☐ Total supplemental life coverage (current plus additional): $_____.
☐ Waive coverage.

BENEFICIARY INFORMATION

(Designate your beneficiary(ies) below. Percentages must total 100%, using whole percentages only. If additional space is required please attach a separate signed and dated document with the same information for each beneficiary.)

	Name *(First, MI, Last)*	DOB	Gender	SSN / TIN	Relationship	%	Beneficiary Type
1			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
2			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
3			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee Signature _____ Date _____

Order #171277 06/08/2015

FRAUD WARNINGS

Arkansas, Maine, Ohio, Oklahoma, Rhode Island, Tennessee, Washington, West Virginia: Any person who, knowingly 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 may subject such person to criminal and civil penalties, and denial of insurance benefits.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: 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.

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.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

San Joaquin County Employees' Retirement Association
6 S. El Dorado Street, Suite 400 • Stockton, CA 95202 • (209) 468-2163 • contactus@sjcera.org • www.sjcera.org

BENEFICIARY DESIGNATION

Please type or print in ink. Please refer to the instructions for this form if you have any questions or contact our office.

MEMBER

First Name	Middle Name	Last Name	
Mailing Address			CAPS (Employee) ID Number
City	State	Zip Code	Date of Birth
Home Telephone Number	Work Telephone Number		Social Security Number
E-Mail Address			○ Male ○ Female ○ Single ○ Married

PRIMARY BENEFICIARIES

I hereby designate the following person(s) who survive me as beneficiaries for death benefits under the County Employees' Retirement Law of 1937 in the event of my death. I understand that if I die after becoming eligible for service retirement, this beneficiary designation may be superceded in certain cases and benefits paid according to law to my eligible surviving spouse or minor children; or, if my death is determined to be service connected, special death benefits will be paid in the manner prescribed by law. If no percentage (%) share is designated, benefits will be paid share and share alike.

1	Name First Middle Last			Social Security Number	
	Mailing Address			Relationship to Member	Date of Birth
	City	State	Zip Code	Telephone	Percent Share %
2	Name First Middle Last			Social Security Number	
	Mailing Address			Relationship to Member	Date of Birth
	City	State	Zip Code	Telephone	Percent Share %
3	Name First Middle Last			Social Security Number	
	Mailing Address			Relationship to Member	Date of Birth
	City	State	Zip Code	Telephone	Percent Share %

If you wish to designate additional primary beneficiaries, please list their name(s), address(es), SSN(s) and relationship(s) to you and share(s) on a separate piece of paper and attach it to this form. ☐ Additional beneficiaries listed on attached.

SIGNATURE

By this beneficiary designation, I hereby revoke any previous designation I have filed. I understand that my marriage, initiation of dissolution or annulment of my marriage, or the birth or adoption of a child subsequent to the date I execute this form may void this designation.

Member Signature	Date	Witness Signature (cannot be a beneficiary)	Date
By signing the beneficiary designation form, I acknowledge the information entered by my spouse. Spouse Signature:	Date	Print Witness Name	

☐ I certify under penalty of perjury that I am not currently legally married (e.g., divorced, widowed, or never married)

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DESIGNATION OF BENEFICIARY

The Basic Death Benefit payable by the SJCERA upon the death of a member prior to retirement consists of the member's accumulated contributions and interest, plus up to six months of the member's final average monthly salary, depending on the years of retirement service credit. This benefit is also referred to as the "lump sum death benefit." The member's surviving spouse or minor children may be eligible for other benefits in lieu of the Basic Death Benefit. These other benefits are also referred to as "survivor continuance." Please refer to the SJCERA Retirement Plan Information booklet for further details concerning pre-retirement death benefits.

Please complete the Beneficiary Designation (Form 110) to designate a beneficiary or beneficiaries to receive the lump sum death benefit payable from the SJCERA in the event of your death prior to retirement.

- You may designate any person(s) or your estate as beneficiaries.
- You may designate a minor child as your beneficiary. **Do not** name a guardian of the minor child in addition to, or instead of, the minor child. If benefits are payable to a minor child, the court-appointed guardian will be responsible for any benefits paid to the child. (Note: A parent who has custody of a minor child is not required to be appointed by the court as a guardian in order to claim a benefit on behalf of that child.)
- You may designate a trust as your beneficiary. However, if you wish to designate a trust, the following information should be provided: The name of the trust, date of trust and name/address of the person with whom the trust is on file.

Also, unless you specify otherwise, the beneficiary you designate on Form 110 will also be the beneficary for any group life insurance benefits provided by your employer (San Joaquin County) for which you may be eligible.

INSTRUCTIONS FOR COMPLETING FORM 110

1. MEMBER INFORMATION

a. Enter your full legal name (no middle initials), social security number, date of birth, current mailing address, and home and work telephone numbers.

b. Enter your e-mail address if you have one. This is voluntary and your e-mail address will remain confidential with the SJCERA.

c. Fill-in the appropriate bubble to specify your gender and current marital status.

2. PRIMARY BENEFICIARIES

Use this section of the form to designate the beneficiary or beneficiaries who are to receive the lump sum death benefit benefit payable from the SCJERA in the event of your death prior to retirement. **If you are legally married and designate someone other than your spouse as your beneficiary, your spouse may still be entitled to his/her community property interest in the lump sum and/or survivor continuance death benefits.**

For each primary beneficiary, you must designate:

a. Full first, middle and last name, Social Security number, complete mailing address, birthdate, and relationship to you.

b. If you designate more than one beneficiary, designate the percentage share to be distributed to each beneficiary. The total of all shares listed must equal 100%.

Example A: If you have two beneficiaries listed and you would like each of them to receieve half of your lump sum death benefit, enter "50" for each beneficiary in the "Percentage Share" box.

Example: B: If you designate only one primary beneficiary, enter "100" in the "Percentage Share" box.

(CONTINUED NEXT PAGE)

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INSTRUCTIONS FOR COMPLETING FORM 110 - CONTINUED

c. If you want to designate more than three primary beneficiaries, please **ATTACH a separate piece of paper** listing your additional beneficiaries and include all of the same information required. Please write your name and Social Security number at the top of any attached page(s). Fill in the bubble for "Additional beneficiaries listed on attached".

NOTE: ALL primary beneficiaries will be concurrent, rather than successive or contingent, payees.

3. SIGNATURE

a. You must sign and date the form in the presence of a witness (other than a named beneficiary) using your full first, middle, and last name. (Example: John Edward Smith.) An unsigned form is not valid and will be returned to you.

b. If you are married, your spouse must sign and date the form, in the presence of a witness, to acknowledge the names of the beneficiaries you are designating.

c. Have the witness clearly sign and date the form.

NOTE: IF YOU ARE UNABLE TO OBTAIN YOUR SPOUSE'S SIGNATURE, YOU MUST COMPLETE AND RETURN THE JUSTIFICATION FOR NON SIGNATURE OF SPOUSE (FORM 112).

4. SUBMIT FORM

Submit the completed, signed, and witnessed Beneficiary Designation form to the SJCERA via U.S. mail, inter-office mail, or in person to the address shown at the top of the Beneficiary Designation Form. If required, also submit completed Justification for Non Signature of Spouse (Form 112).

IMPORTANT NOTICE

Your Beneficiary Designation may be revoked automatically if any of the following events occur subsequent to the date you execute and submit this Beneficiary Designation form:

a. Marriage; or
b. Dissolution or annulment of marriage **if effected after** the Beneficiary Designation form was submitted; or
c. Birth or adoption of a child; or
d. Termination of employment and withdrawal of your contributions from the SJCERA.

If your beneficiary designation is revoked by one of the above events, benefits will be paid to your statutory beneficiaries (pursuant to the California Probate Code), unless you submit a new Beneficiary Designation to SJCERA. You may request a blank form from SJCERA or download it from our web site at www.sjcera.org.

IF YOU HAVE ANY QUESTIONS ABOUT COMPLETING AND SUBMITTING THIS FORM, PLEASE CONTACT THE SJCERA AT 209-468-2163.

San Joaquin County Employees' Retirement Association
6 S. El Dorado Street, Suite 400 • Stockton, CA 95202 • (209) 468-2163 • (209) 468-0480 Fax • www.sjcera.org

JUSTIFICATION FOR NON-SIGNATURE OF SPOUSE

If you are legally married and your spouse's signature does not appear on your SJCERA Beneficiary Designation (Form 110), you **MUST** complete and sign this form and submit it with your Beneficiary Designation. Your Beneficiary Designation will not be accepted by the SJCERA without this Justification for Non-Signature of Spouse.

MEMBER

First Name	Middle Name	Last Name	
Mailing Address			Social Security Number
City	State	Zip Code	Date of Birth
Home Telephone Number	Work Telephone Number		○ Male ○ Female
E-Mail Address			

JUSTIFICATION FOR NON SIGNATURE

I am married, but my legal spouse did not sign my SJCERA Beneficiary Designation (Form 110) because either (check **ONLY ONE** of the following):

- ☐ I do not know the whereabouts of my spouse and I have undertaken all reasonable steps necessary to locate my spouse without success; **OR**
- ☐ My spouse has been advised of the application and has refused to sign the written acknowledgement; **OR**
- ☐ My spouse is incapable of executing the acknowledgement because of an incapacitating mental or physical condition; **OR**
- ☐ My spouse has no identifiable community property interest in the benefit; **OR**
- ☐ My spouse and I have executed a marriage settlement agreement which makes the community property law inapplicable to the marriage.

SIGNATURE

I certify under penalty of perjury that the foregoing information is true and correct.

Member Signature	Date

San Joaquin County Employees' Retirement Association

6 S. El Dorado Street, Suite 400 Stockton, CA 95202 • (209) 468-2163 • ContactUs@sjcera.org

Membership Certification

Complete and **return this form to your Personnel Office within 3 business days of your start date. Attach a copy of your birth certificate or valid passport**. If you do not have a birth certificate or valid passport, or are unable to obtain one, see the **Age Verification Policy** on www.sjcera.org for other acceptable documents.

1. Member Information

First Name	MI	Last Name	Cell Phone

SSN	Date of Birth	Employee ID Number

2. Previous Employment & Reciprocity

*Previous employment information is needed to determine tier, contribution rate, and eligibility for reciprocity. Reciprocity allows members to move from one eligible government retirement system to another and retain valuable retirement benefits. (**See instructions on back**)*

Most Recent Previous Employer	Retirement System (Refer to list of systems on the back)

Last Date of Employment (under most recent reciprocal retirement system)	First Membership Date (in any previous reciprocal retirement system)

Check applicable statement:	Payroll Use
☐ I have not been an active member of another reciprocal California government retirement system within the last six months. (Active members are generally permanent full-time employees. See list of retirement systems on back.)	Tier 2
☐ I retired from _____ retirement system and subsequently began full-time employment with an SJCERA-participating employer.	Tier 2
☐ I was a member of the _____ retirement system and, within six months, subsequently began full-time employment with a SJCERA-participating employer.	--
☐ My reciprocal system membership began before Jan. 1, 2013 and I left my member contributions on deposit with that retirement system.	Tier 1
☐ My reciprocal system membership began on/after Jan. 1, 2013 or I withdrew (refunded) my member contributions from that retirement system	Tier 2

3. Acknowledgement

I have read this form and its instructions in their entirety. I hereby certify that the foregoing information is true and correct. I understand that incorrect information may require corrections to my SJCERA account including, but not limited to, my membership date, tier and contribution rate. I authorize SJCERA to establish reciprocity if I am eligible and make any necessary corrections to my account including collecting additional contributions if owed.

EMPLOYEE SIGNATURE	DATE

4. Employer Certification *(**See instruction on back**)*

Employing Agency/Department	New Employee's Job Class Title	Employee Hire Date

Employer Designee (signature)	Designee Title	Date

Employee Instructions

Complete and submit this form with a copy of your birth certificate or other proof-of-age documents to your Personnel Office within 3 business days of beginning employment. For more information, visit www.sjcera.org or call 209.468.2163.

Section 2 Instructions: Previous Employment and Reciprocity Information

Your prior public plan benefit information is required to correctly determine your Tier and contribution rate.

Previous Employment with a SJCERA-employer

If you are a Tier 1 member whose contributions remained on deposit with SJCERA when you left SJCERA-covered employment, and you return to a full-time permanent position with the same SJCERA employer within six months, you will retain your previous SJCERA entry age and contribution rate. If you return to the same employer in more than six months, your entry age and contribution rate will be based on your age at reentry into membership. If you return to a different SJCERA-employer after more than six months, you will be placed in Tier 2.

SJCERA Employers		
San Joaquin County	Mountain House Community Svcs. Dist.	SJC Mosquito & Vector Control
Lathrop-Manteca Fire District	SJC Historical Society & Museum	SJC Superior Court
SJC Law Library	Tracy Public Cemetery	Waterloo-Morada Fire District

Previous Employment with another California Government Employer (Reciprocity)

If you were a member of a reciprocal California government retirement system (see list below) within the last six months, reciprocity allows you to link your entry age, service credit and highest average compensation across all your reciprocal systems. Reciprocity may also allow you enter SJCERA as a Tier 1 member, which offers a higher benefit formula.

Reciprocal Retirement Systems				
County Retirement Systems				
Alameda	Kern	Merced	San Diego	Sonoma
Contra Costa	Los Angeles	Orange	San Joaquin	Stanislaus
Fresno	Marin	Sacramento	San Mateo	Tulare
Imperial	Mendocino	San Bernardino	Santa Barbara	Ventura
State Retirement Systems				
CalPERS (California Public Employees Retirement System)	CalSTRS (California State Teachers' Retirement System)	Legislators' Retirement System (LRS)	Judges Retirement System (JRS)	

Tiers

Tier 1 Members: Employees who entered SJCERA membership before January 1, 2013, or who establish incoming reciprocity based on eligible reciprocal system membership before January 1, 2013.

Tier 2 Members: Employees who enter SJCERA membership on or after January 1, 2013; Tier 1 members who terminate and return to a different SJCERA-participating employer after more than six months; SJCERA retirees who return to active membership.

Employer Instructions

1. Collect this *Membership Certification* form from all new or returning full-time benefited employees, verify the date of birth is entered correctly and complete the Employer Certification section.
2. Submit the following completed forms and documents directly to SJCERA within the first week of employment:
   - ☐ Member Certification
     - ☐ Copy of the employee's Birth Certificate, valid U.S. Passport or valid California Real I.D. Card
       See the Age Verification Policy on www.sjcera.org for other acceptable documents.
   - ☐ Beneficiary Designation
   - ☐ Safety Only – Social Security Form SSA-1945 (if applicable)

GROUP TERM LIFE INSURANCE
BI-WEEKLY RATES FOR ADDITIONAL INSURANCE

The County provides Group Term Life Insurance for all employees who are eligible for County benefits. Eligible employees may purchase additional insurance in $25,000 increments from the County's current insurance carrier, ReliaStar. Payroll deductions for additional life insurance are deducted bi-weekly.

All members may purchase up to $200,000.

COVERAGE	BI-WEEK RATE	COVERAGE	BI-WEEK RATE	COVERAGE	BI-WEEK RATE	COVERAGE	BI-WEEK RATE
$25,000	$3.20	$50,000	$6.39	$75,000	$9.59	$100,000	$12.78
$125,000 *	$15.98	$150,000 *	$19.17	$175,000 *	$22.37	$200,000 *	$25.56

Evidence of Insurability Required for Amounts over $100,000 and any amount after 31 days from date of hire.

SAN JOAQUIN COUNTY
Greatness grows here.

County of San Joaquin, CA
457(b) Deferred Compensation Plan
Participation Agreement & Service Request

Personal Information

Plan Name: County of San Joaquin 457(b) Plan Plan ID: 0062668001

Name: _____ SSN: _____

Date of Birth: _____ Date of Hire: _____ Primary Phone: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Email: _____

How would you like to be contacted if additional information is required? ☐ Phone ☐ Email

Paperless Delivery Consent

Paperless Delivery: By providing your email address you are consenting to electronic (paperless) delivery of documents related to your retirement plan, e.g. - statements, confirmations, terms, agreements, etc. Check the box below if you would prefer to receive paper copies of the documents via US Mail to the address provided above.

☐ **I do NOT consent to Paperless Delivery. Please provide the documents related to my retirement plan via US Mail.**

Deferral Election

457(b) Pre-Tax $ _____ OR _____% Payroll Frequency: Bi-Weekly

457(b) Roth After -Tax $ _____ OR _____% Start Contribution On (Pay Period): _____

Total **$** _____ **OR** _____**%**

☐ **Enroll me in asset rebalancing** I agree to comply with and be bound by the terms and conditions of the service including any restrictions imposed by the investment options. I understand I can obtain more information about the service, its terms and conditions by contacting the Nationwide Service Center.

NOTE: All increases, decreases and suspensions will be implemented no sooner than the first payroll of the month following the change. Please remember to check your paystub to confirm your selected deferral is accurately reflected and being processed.

Beneficiary Designation

IMPORTANT NOTES: 1) Allocations must total 100% for each category of beneficiary; and 2) If you designate a single primary or contingent beneficiary and do not list a percentage, it will be designated as 100%.

☐ **I have additional beneficiaries.** If you want to designate more than 2 of each type of beneficiary, you may attach a page with the additional beneficiary information. Allocations must still total 100% for each category.

Primary Beneficiary(ies) (Allocations must total 100%):

1. **Full Name:** _____ Allocation: _____%
   Relationship: _____ SSN: _____ Date of Birth: _____
   Address: _____ Phone: _____
2. **Full Name:** _____ Allocation: _____%
   Relationship: _____ SSN: _____ Date of Birth: _____
   Address: _____ Phone: _____

Contingent Beneficiary(ies) (Allocations must total 100%):

1. **Full Name:** _____ Allocation: _____%
   Relationship: _____ SSN: _____ Date of Birth: _____
   Address: _____ Phone: _____
2. **Full Name:** _____ Allocation: _____%
   Relationship: _____ SSN: _____ Date of Birth: _____
   Address: _____ Phone: _____

Funding Options

Asset Allocation

_____% T. Rowe Price Retirement I 2015 I

_____% T. Rowe Price Retirement I 2020 I

_____% T. Rowe Price Retirement I 2025 I

_____% T. Rowe Price Retirement I 2030 I

_____% T. Rowe Price Retirement I 2035 I

_____% T. Rowe Price Retirement I 2040 I

_____% T. Rowe Price Retirement I 2045 I

_____% T. Rowe Price Retirement I 2050 I

_____% T. Rowe Price Retirement I 2055 I

_____% T. Rowe Price Retirement I 2060 I

_____% T. Rowe Price Retirement I 2065 I

_____% T. Rowe Price Retirement Balanced I

Small Cap

_____% Vanguard Small Cap Index I

_____% Vanguard Small Cap Growth Index Admiral

_____% DFA US Targeted Value I

Mid Cap

_____% Vanguard Mid Cap Index I

_____% Allspring Spec Mid Cap Val R6

_____% MFS Mid Cap Growth R6

Large Cap

_____%Vanguard Institutional Index I

_____% Vanguard Equity-Income Admiral

_____% T.Rowe Price Institutional Large-Cap Growth

International

_____% American Beacon Intl Equity R6

_____% Vanguard International Growth Admiral

Bonds

_____% DFA Inflation-Protected Securities I

_____% Metropolitan West Total Return Bond

_____% TIAA-CREF High-Yield Institutional

_____% Vanguard Total Bond Market Index Admiral

Specialty

_____% Invesco Gold & Special Minerals R6

_____% Invesco Real Estate R6

Fixed/Cash

_____% Nationwide Fixed Fund

__100__% Total for all funding options must equal 100%[1]

[1] If I select an investment option that is closed or unavailable, or if I elect a total investment allocation percentage that is less than 100%, I agree that the money will be placed into the T.Rowe Price Retirement Fund closest to my anticipated retirement age, based upon my date of birth and a normal retirement age of 62, which is the default investment option. If I elect a total investment allocation percentage greater than 100%, I agree that my application will be rejected and my selections will not be processed.

Authorization

☐ Please send me a copy of the Informational Brochure/Prospectus(es).
☐ Please contact me regarding transferring my other pre-tax retirement plans.
☐ Please send me forms regarding the Catch-up Provisions.

I hereby elect the deferral amount stated above. I understand my deferral will continue until otherwise authorized in accordance with the Plan. The deferrals will be allocated to the funding options in the percentages elected above. I understand some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

I have read and understand the terms contained in this form. I accept these terms and understand that the terms contained in this form do not cover all the details of the Plan or products.

Signature: _____ **Date:** _____

Retirement Specialist Name (Print): _____ **Agent #:** _____

Form Return

By mail: Nationwide Retirement Solutions
PO Box 182797
Columbus, OH 43218-2797

By email: rpublic@nationwide.com
By fax: 877-677-4329

The purpose of the Memorandum of Understanding is to make you aware of some of the highlights, restrictions and costs of your plan. It is not intended to cover all aspects of the plan and should not be relied upon in making decisions about plan benefits.

I understand and acknowledge the following:

1. The maximum annual contribution amount to all 457(b) plans is the lesser of the maximum annual 457(b) contribution limit or 100% of my includible compensation. This amount may be adjusted annually. If you have questions about the maximum contributions limits they can be found at irs.gov. Under certain circumstances, additional amounts above the limit may be contributed to the Plan if (1) I will attain age 50 or older during the current calendar year, or (2) I am within three years of the Plan's Normal Retirement Age and did not contribute the maximum amount to the 457(b) Plan in prior years. The Plan Document provides additional details about contribution limits. Contributions in excess of maximum amounts are not permitted and will be reported as taxable income when refunded. It is my responsibility to ensure my contributions to all 457(b) plans in which I participate regardless of employer do not exceed the annual limit.
2. It is my responsibility to adjust my contribution amount to comply with applicable limits. Excess deferrals will be returned to me and reported on IRS tax Form 1099-R. I acknowledge that it is my responsibility to make sure my total contributions fall within the specified limits. A Nationwide Retirement Solutions, Inc. ("NRS") representative can provide assistance in determining my contribution limits.
3. I may withdraw funds from the Plan only upon separation from service; at age 70½; upon an unforeseeable emergency approved by the Plan; when taking a loan or, I may take a one-time in service withdrawal if my account value is $5,000 or less (as adjusted) and I have not contributed to the Plan for two or more years. In some cases, withdrawal for purchase or repayment of service credits in a Governmental Defined Benefit Plan may be permitted. Additionally, funds may be withdrawn upon my death. All withdrawals of funds must be in compliance with the Internal Revenue Code (the "Code") and applicable regulations as expressed in the Plan Document.
4. Contributions, in the form of salary reductions, will be made until I notify NRS or my Plan Sponsor otherwise. Once notification is received salary reductions will be changed as soon as administratively feasible.
5. Contributions will be invested as soon as administratively feasible upon receipt from the Plan Sponsor.
6. My participation in the Plan is governed by the terms and conditions of the Plan Document. Fund prospectuses are available upon request at sanjoaquindc.com or by calling 877-677-3678.
7. My distributions must begin no later than the April 1st following the later of the year I reach age 72 or have a severance from employment. Please consult the Plan Document for further details. Generally, all pre-tax distributions are taxable as ordinary income and subject to income tax in the year received. My distributions must be made in a manner that satisfies the minimum distribution requirements of the Code section 401(a)(9), which currently requires benefits to be paid at least annually over a period not to extend beyond my life expectancy. Failure to meet minimum distribution requirements may result in my being subject to a 50% federal excise tax.
8. The funds in my accounts may be eligible for rollover to a traditional or Roth IRA or to another eligible retirement plan. The "Special Tax Notice Regarding Plan Payments" provides detailed information about my options. Due to important tax consequences related to distributions, I have been advised to consult a tax advisor. I expressly assume the responsibility for tax consequences relating to any distribution, and I agree that neither the Plan nor the Administrative Services Provider shall be responsible for those tax consequences.
9. All amounts contributed to the Plan and earnings on the amounts contributed are held in a trust, custodial account or annuity contract for the exclusive benefit of the participants and their beneficiaries.
10. Underlying investment options may be periodically changed or restricted.
11. NRS will permit participants and beneficiaries to exchange amounts among the Variable and Fixed investment options as frequently as permitted by the Plan, subject to the limits and rules set by each Fund and the Contract. Changes may be made by calling 877-677-3678 or logging on to sanjoaquindc.com. Options for investments may vary by the source of the money invested.
12. If I select an investment option that is closed or unavailable, or I elect a total investment allocation percentage that is less than 100%, I agree that the money will be placed into the T.Rowe Price Retirement Fund closest to my anticipated retirement age, based upon my date of birth and a normal retirement age of 62, which is the default investment option. If I elect a total investment allocation percentage greater than 100%, I agree that my application will be rejected and my selections will not be processed.
13. The Plan may have investment management fees, depending on the mutual funds in which I invest. For more information, please call 877-677-3678.
14. Any beneficiary designation I made on this form will supersede any prior beneficiary designation and shall become effective on the date accepted by the Plan, provided that this designation is accepted by the Plan prior to my death. Further, that any benefits payable at my death shall be paid in substantially equal shares to my beneficiaries unless I specify otherwise. My death benefits will be paid first to my Primary beneficiaries. If any of my Primary Beneficiaries predecease me, then my death benefits will be paid to the remaining Primary Beneficiaries. Contingent Beneficiaries will only receive benefits if no Primary Beneficiary survives me. If no beneficiary designation is on file, benefits will be paid as set forth in the Plan Document.
15. I must notify NRS of any beneficiary changes, address/contact information changes, contribution changes, allocation changes or errors on my account statement.
16. I will receive a statement of my account quarterly.
17. All telephone exchange requests will be recorded for the participant's protection.
18. Transfers between investment options are provided for under the Plan subject to limitations or restrictions (including redemption fees), if any, as imposed by the investment providers. I understand that any information regarding limitation or restrictions as they apply to the Plan may be obtained from the Plan Administrator.
19. If applicable, I understand that no changes will be effective until they are processed by NRS.

Mutual Fund Payments Disclosure

Nationwide offers a variety of investment options to public sector retirement plans through variable annuity contracts, trust or custodial accounts. Nationwide may receive payments from mutual funds or their affiliates in connection with those investment options. For more detail about the payments Nationwide receives, please visit sanjoaquindc.com.

Endorsement Disclosure

Nationwide has endorsement relationships with the National Association of Counties, United States Conference of Mayors, and the International Association of Firefighters Financial Corporation. More information about the endorsement relationships may be found online at sanjoaquindc.com.

Consent to Paperless Delivery and Access

By providing your email address on this form, you are agreeing and consenting to receive and view plan benefit statements, correspondence and confirmations, and other communications electronically. These materials will be provided through an e-mail message notifying you that electronic documents are available online for you to view and print. This replaces all written communication associated with your Retirement Plan(s) serviced by Nationwide and you will no longer receive these documents via US Mail.
By providing your consent to paperless delivery, you are acknowledging and confirming that you are consenting to receive Plan Communications electronically, as they are now available or as they may be required or become available in the future and that you have access to view and print your documents electronically from the website and to save them from your computer or other electronic device. If you would like to receive the above referenced documents in paper form via US Mail you can do so by contacting Customer Service at 877-677-3678 and request paper. You may opt out of paperless delivery of your plan related documents at any time. There is no additional cost to receive documents in paper format via US Mail.

Changing Your Email Address and Your Paperless Delivery Preferences

You are able to update your email address or change your Paperless Delivery Preferences anytime either on the web site or via Customer Service.

Your Right to Revoke Consent

You have the right to revoke your consent to receive documents electronically. Your consent shall be effective until you revoke it by changing your delivery preferences via Customer Service or on the website by selecting US Mail delivery.

Security when you travel

Voya Travel Assistance

We live in a highly connected world where frequent domestic and international travel is the norm. Voya Travel Assistance offers you enhanced security for your leisure and business trips. You and your dependents will have toll-free or collect-call access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year – from anywhere in the world. Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

Available services

When traveling more than 100 miles from home, Voya Travel Assistance offers you and your dependents four types of services: Pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

Pre-trip information

These valuable services help you start your trip the right way. Voya Travel Assistance can provide you with important, up-to-date travel information including:

- Immunization requirements
- Visa & passport requirements
- Foreign exchange rates
- Embassy/consular referral
- Travel/tourist advisories
- Temperature & weather conditions
- Cultural information

Emergency personal services

In the event of an unexpected situation of a non-medical nature, Voya Travel Assistance offers access to several valuable services, including:

- Urgent message relay
- Interpretation/ translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage or personal possessions
- Legal assistance and/or bail bond

If you need emergency or pre-trip services...

...use the contact information on the reverse and identify yourself as an eligible participant in the Voya Travel Assistance program.

You will be asked to provide some additional information in order to confirm your eligibility under this program. Once your eligibility has been verified, Voya Travel Assistance will arrange and provide the emergency transportation services previously described.

Please note: Services are only eligible for payment through Voya Travel Assistance if Voya Travel Assistance was contacted at the time of service and arranged for the service. If costs are incurred for other services, you are responsible for those costs or reimbursement of those costs if initially paid by Voya Travel Assistance; Voya Travel Assistance will ask for your credit card and debit your account for the required amount.

Voya Travel Assistance

Contact Voya Travel Assistance 24 hours a day, 365 days a year for: pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

Group name: CSAC-EIA / Group number: 316407
In the US, toll-free: 800.859.2821
Worldwide, collect: 202.296.8355
Email: ops@europassistance-usa.com
Online portal:
https://eservices.europassistance-usa.com/sites/Voya
Group ID: N1VOY
Activation code: 140623

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

PLAN | INVEST | PROTECT

VOYA® FINANCIAL

Emergency transportation services*

Should you need medical care or assistance while traveling, Voya Travel Assistance can help. When deemed medically necessary by a Voya Travel Assistance- designated physician, evacuation and transportation to the nearest adequate medical facility that can properly treat your condition will be arranged and paid for on your behalf. Additional transportation services include:

- Visit of family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

* The services listed above are subject to a maximum total payment of $150,000.

Medical assistance services include:

- Medical referrals for local physicians and dentists
- Medical case monitoring
- Prescription assistance and eyeglass replacement
- Arrangement and payment of emergency medical services (up to $10,000 with a written guarantee of reimbursement from the eligible participant)

How it works

At any time before or during a trip, you may contact Voya Travel Assistance for assistance services. It is recommended that you keep a copy of this summary with your travel documents. Use the wallet card to have convenient access to the numbers that you need.

Exclusions and limitations

A. Voya Travel Assistance shall not provide services enumerated above if the service is sought as a result of your or your dependent's:

Involvement in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, and insurrection, military or usurped power;

- Travel against the advice of a physician;
- Travel for the purpose of obtaining medical treatment;
- Travel in any country in which the U.S. State Department issued travel restrictions;
- Commission of or attempt to commit an unlawful act;
- Being under the influence of drugs or intoxicants unless prescribed by a physician;
- Pregnancy and childbirth (except for complications of pregnancy);
- Mental or emotional disorders, unless hospitalized;
- Participation as a professional in athletics;
- Services provided for which no charge is normally made;
- Travel within 100 miles of your permanent residence, unless in a foreign country.

B. The services described above currently are available in every country of the world. Due to political and other situations in certain areas of the world, Voya Travel Assistance may not be able to respond in the usual manner.

It is your responsibility to inquire whether a country is "open" for assistance prior to your departure and during your stay. Voya Travel Assistance also reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, acts of God or refusal of authorities to permit Voya Travel Assistance to fully provide services.

C. If you request a transport related to a condition that has not been deemed medically necessary by a physician designated by Voya Travel Assistance in consultation with a local attending physician or to any condition excluded hereunder, and the Employer or Plan Sponsor agrees to be financially responsible for all expenses related to that transport, Voya Travel Assistance will arrange but not pay for such transport to a medical facility or to your residence and will make such arrangements using the same degree of care and completeness as if Voya Travel Assistance was providing service under this agreement. A waiver of liability will be required prior to arranging these transportation services.

D. Voya Travel Assistance shall not be responsible for any claim, damage, loss, cost, liability or expense which arises in whole or in part as a result of Voya Travel Assistance's inability to reach the Employer's or Plan Sponsor's authorized Contact person for any reason beyond Voya Travel Assistance's control, or as a result of the failure and/or refusal of the Employer or Plan Sponsor to authorize services proposed by Voya Travel Assistance.

Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

Products and services may not be available in all states.

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

204331-02012019

Peace of mind
when it's needed the most

Funeral Planning Services

Available to employees who are covered for group life insurance through their employer. Funeral planning and concierge services are provided by Everest Funeral Package, LLC.

Everest is pleased to provide a value-added service that empowers individuals who are dealing with funeral related issues.

While you can't predict life's outcome,
you can prepare for it.

EVEREST
FUNERAL CONCIERGE

Who is Everest?

Everest, the first nationwide funeral planning and concierge service, is an independent consumer advocate who works on your behalf. Everest's sole purpose is to provide the information you need to make the most informed decisions about all funeral related issues and then put those wishes into action.

You're never locked into a decision because Everest's funeral advisory services can be used at any funeral home across North America.

Everest is an impartial consumer advocate, not a funeral home. Everest does not sell funeral goods or services, nor does Everest receive any commissions from funeral homes or other service providers in the funeral industry. With Everest, you are removed from a sales-focused environment, allowing you and your family to make well-informed and confident decisions during a stressful time.

Everest offers both pre-planning and at-need services at or near the time of need. Everest's online planning tools help you prepare for the future. At-need services include price negotiation assistance and communicating the family's wishes to the funeral home. Everest Advisors are available by phone 24/7 and can determine eligibility for the expedited life insurance claim process.

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

VOYA® FINANCIAL

Everest's services include

Who is eligible?

Everest can be used to plan a funeral for an employee; a spouse or domestic partner; or an employee's dependents up to age 26.*

Pre-planning Services

24/7 advisor assistance

- To discuss funeral planning issues

PriceFinder℠ research reports

- The only nationwide database of funeral home prices
- Detailed, local funeral home price comparisons

Online planning tools

Include

- Personal profile
- "10 key decisions" planner
- "My Wishes" planning guide
- Reference guide

Information stored and maintained in a secure data warehouse

At-need Services

At-need family support

- Family assistance and plan implementation
- Communicate the personal funeral plan to the funeral home, removing the family from a sales-focused environment
- Provide 24-hour assistance throughout the funeral process
- Expedited life insurance claim process. Eligible beneficiaries may have access to a portion of the life insurance funds in as little as two business days following receipt of the claim form.**

Negotiation assistance

- Gather pricing information and present it to the family in an easy-to-read format
- Negotiate funeral service pricing with local funeral homes
- Help the family compare prices of caskets and other products

* Spouse or domestic partner coverage varies depending on the terms of your employer's group life insurance policy.

**Availability may vary by state.

Getting started

Group name: CSAC-EIA
Group number: 316407

Create an online profile and use Everest's planning tools visit **everestfuneral.com/voya**

- Enter your email address and your employer's name
- Create a password and complete your online profile
- Access "Planning Tools"

If you do not have access to a computer, Everest advisors are available 24/7 by calling **1-800-913-8318**.

EVEREST FUNERAL CONCIERGE

Contact your employer for more information.

Funeral Planning and Concierge Services are provided byEverest Funeral Package, LLC, Houston, TX.

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies
Products and services may not be available in all states.

204332-02012019

PLAN | INVEST | PROTECT

VOYA® FINANCIAL

Plan for tomorrow, today.

Everyone knows health insurance doesn't pay for everything. Do you feel fully protected? Reviewing and updating your coverage each year is important.

Get help with your options. Stop by and see an American Fidelity account manager.

Accident Only Insurance

AF™ **Limited Benefit Accident Only Insurance**

- may help manage out-of-pocket costs to treat injuries resulting from a covered accident
- provides benefit payments directly to you

americanfidelity.com/info/accident

Critical Illness Insurance

AF™ **Limited Benefit Critical Illness Insurance**

- pays a benefit upon diagnosis of certain covered life-altering illnesses
- helps with costs not covered by medical insurance

americanfidelity.com/info/critical-illness

Disability Income Insurance

AF™ **Disability Income Insurance**

- can help protect your finances in case of a covered injury or illness
- provides a benefit to help cover costs while you are unable to work
- pays some of your gross monthly earnings

americanfidelity.com/info/disability

Hospital Indemnity Insurance

AF™ **Limited Benefit Hospital Indemnity Insurance**

- helps pay for out-of-pocket costs, like a hospital stay
- when used with a Health Savings Account allows for a tax benefit and potential savings

americanfidelity.com/info/hospital-indemnity

AMERICAN FIDELITY
a different opinion

EMPLOYER BENEFIT SOLUTIONS FOR THE PUBLIC SECTOR

An unintentional injury averages **$4,339** in medical expenses.

National Safety Council, Injury Facts, 2019 Web.

24/7 Access with AFmobile®

Manage your insurance benefits and reimbursement accounts all from the palm of your hand.

View
account balances

Manage
claims and reimbursements

Submit
documentation

Receive
alerts

Maintain
personal information

Get Started

Register at **americanfidelity.com/register** or **download AFmobile** and select the New User link.

Please allow one business day after you enroll before registering for an online account. If you already have an account, your username and password will be the same for AFmobile.

800-654-8489, Ext. 2486
sanjoaquinvoluntarybenefits@americanfidelity.com

American Fidelity Assurance Company
americanfidelity.com

SB-33033-0120