LOCAL 503
SEIU
Stronger Together

SEIU Local 503

2020 年成员优势

成员优势

欢迎！

若您加入并持续成为 SEIU Local 503 成员，则可获得下列福利。详情载于本手册内。

- **您的 SEIU Local 503 支付 2,500 美元的寿险保单**。此保单在您为现任成员的期间生效。您可通过填写本手册第 10 页的登记和受益人委任表委任一名受益人。
- **可在成为新工会成员的前90 天内或在开放登记期购买其他寿险**。在任何其他时间购买的保障需要医疗核保。详情载于本手册第 6 页至第 9 页，登记表在第 10 页。
- **在成为新工会成员的首 90 天内购买的短期残疾保险**将予以担保。在任何其他时间购买的保障需要通过医疗核保予以批准。详情载于本手册第 7 页至第 9 页，及登记表在第 10 页。
- **可在成为新工会成员的前 90 天内或在开放登记期购买登记法律保险**。登记和资格详情载于第 1 页至第 3 页，登记表载于第 4 页。

  成员优势办公室须在新成员成为新工会成员的前 90 天内受理其人寿、短期残疾和法律保险登记表。
- **成员及其配偶 / 伴侣、子女和孙子女可获得** 奖学金。基于财务需求和学科能力颁发奖学金。成为成员满一年后方可申请。下一学年的 11 月中旬至 2 月可有机会申请。
- **面向成员及其家庭成员提供其他福利和折扣。**详情请参阅第 19 页。

成员优势客户服务

1.844.503.SEIU (7348)

电子邮件：membershipadvantages@seiu503.org

再一次欢迎加入我们的工会！

成员优势

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本成员优势手册仅为概要，并未完全描述您能够选择的各种成员优势。如需了解更多信息，请联络SEIU成员优势办公室或参阅您的承保范围说明书。本概要与承保范围说明书冲突时，概以承保范围说明书为准。

LOCAL 503
SEIU
Stronger Together

来自 ARAG® 的法律保险

专门针对 SEIU Local 503 成员

法律保险

法律无处不在。用法律保险保障您和您的家人。

您可曾停下来想过，您的一生中有多少事件涉及法律问题？ 有您欢欣鼓舞的时刻（例如迎接新生命的到来或是买下梦想中的房子），也有您遭遇挑战的时刻（例如当爱情不顺或孩子在法律上遇到麻烦）。

购买来自 ARAG® 的 UltimateAdvisor® 法律保险：

- 针对多种承保范围内的法律事宜**100% 全额支付**您的网络律师费。
- 享受 ARAG 网络内平均拥有 20 年经验的 **14,000 多名律师**的服务。
- 通过网络律师解决您承保范围内的法律情况，只需**打个电话，律师就会为您提供法律帮助和法律代理。**
- **随时可用的线上工具和资源**，其中包括可帮您创建任意 350 多份具有法律效力的文件（包括特定某个州的模板）的 DIY Docs®。

我花钱能买到什么？

内部服务：接达全国性网络内**14,000多名律师，** 获得他们的建议和代理。

电话建议：您可以致电一名网络律师，**无限制获取法律意见，**以帮助您编制个人文件、信函或遗嘱。

线上资源：ARAG 提供线上工具和有用信息，供您自行了解更多法律事务。使用我们的 DIY Docs® 帮助您创建任意350多种具有法律效力的文件，包括特定某个州的模板。

ARAG 法律保险可平均为您的每件法律事项节省 2,065[1] 美元。

需要多少费用?

家庭保险：每月 21.49 美元

个人保险：每月 16.29 美元

如有疑问或希望获得更多计划信息

- 请致电成员优势，电话号码是 1.844.503.SEIU (7348)
- 登录网站 ARAGlegal.com/plans，接入码为 10540sei
- 周一至周五太平洋时间上午 5:00 至下午 5:00，拨打 ARAG 客户服务电话 1.800.247.4184

税务服务及身份盗窃保护！

我们理解，有时候生活中的财务状况可能会变得复杂，特别是当您处理个人税务问题时。现在，当您需要专家税务意见和相关服务时，您随时有地方可以求助。只需一个电话，您就能获得经验丰富的专业税务专家的一对一咨询。而且，不要忘记您还可享受身份盗窃保护。此服务可以监控您的信用档案和线上身份的变动，并就可疑活动向您发出通知。

来自 ARAG® 的法律保险

UltimateAdvisor® 法律保险计划详情

依靠广泛的承保范围和服务（如下面的例子），解决您在生活中可能遇到的家庭、法律和财务问题：

以下只是您可获得的部分福利。承保事项的完整清单，请登录网站 ARAGLegal.com/plans，接入码 10540sei。

消费者事项
- 汽车维修
- 买车 / 卖车
- 欺骗消费者
- 承包商

遗产规划
- 遗嘱
- 修改遗嘱
- 生前遗嘱
- 授权书
- 遗产管理（最多 9 小时）

债务
- 破产
- 讨债
- 技工留置权
- 学生贷款债务合并

民事损害辩护
- 诽谤 / 中伤
- 与宠物相关的事项

家庭
- 领养
- 赡养费
- 子女抚养费
- 子女监护权
- 离婚（提出争议至最多 15 小时）
- 婚前协议
- 家庭暴力
- 监护 / 接管
- 精神错乱 / 衰弱
- 改名
- 父母责任

房地产
- 房屋买卖
- 止赎
- 邻居纠纷
- 房地产纠纷

税务
- 国税局税务审计
- 国税局征税

交通（未酒后驾驶）
- 暂时吊销 / 撤销
- 交通罚单（1x 每年）

与房东的争议
- 合同 / 租约
- 迫迁
- 押金

刑事事项
- 延长聘任时间
- 人身保护令
- 青少年
- 轻罪

一般事项
- 本票
- 契约
- 个人财产保护

对于任何其他未涵盖亦未排除在外的事项，您将在网络律师正常费率基础上享受至少 25% 的减免。

别急，还有更多内容！

选择 UltimateAdvisor，您还能享受：

- 身份盗窃保险：最高为 100 万元身份恢复相关开支提供保障[2]
- 全方位身份恢复服务：恢复专业人员可代您证明您的清白及恢复您的身份。
- 钱包遗失服务：恢复专业人员将帮您注销及补发信用卡、驾照等。
- 一局信用监控：监控您信用报告的变化情况。
- 互联网监视：监控网络及其他数据点，如发现您的个人信息被交易和 / 或出售，则发出警告提醒您注意。
- 子女身份监控：监控您未成年子女的身份，如发现他们的个人信息被交易和 / 或出售，则发出警告提醒您注意。
- 地址变更监控：如果有人向美国邮政总局提交您的地址对应的地址变更请求，则会为您提示。
- 金融教育和咨询服务，由训练有素的财务顾问就各种主题提供指导和解答。
- 看护热线提供来自网络律师的法律建议和老年人护理专业人员的看护服务，协助您护理您的父母及祖父母。

如有疑问或希望获得更多计划信息：
- 请致电成员优势，电话号码是 1.844.503.SEIU (7348)
- 登录网站 ARAGlegal.com/plans，接入码为 10540sei
- 周一至周五太平洋时间上午 5:00 至下午 5:00， 拨打 ARAG 客户服务电话 1.800.247.4184

自 2020 年 1 月 1 日起生效的法律计划变更包括：
- 增加社会保险、退伍军人保险和医疗保险。
- 去除对少年法庭重罪的覆盖。提供降低费用这一福利。

"ARAG 让处理法律事务的经历比靠自己孤军奋战容易得多。我不必四处寻找律师或是支付巨额费用。"

加州旧金山 Donna

前往网站 ARAGLegal.com 查阅来自真实计划成员的评论。

限时登记：

切勿错过登记加入可负担法律保障的机会。只需填写第 4 页的登记表并寄回至：

SEIU Local 503
PO Box 12159
Salem, OR 97309

家庭：每月 21.49 美元
个人：每月 16.29 美元

法律保险

来自 ARAG® 的法律保险

资格要求

新成员 — 在成为 SEIU Local 503 成员后 90 天内即有资格登记参保。已登记参保的成员可以让自己的配偶或符合资格的家庭伴侣和该成员或其配偶/伴侣所有未满 26 岁的受抚养未婚子女登记参保。如果新成员的受抚养未婚子女年龄在 26 周岁（含）以上且身体残疾，并且您或您的配偶/伴侣是他们的法院指定法定监护人，则可以让子女登记参保。必须随登记表提交监护权相关文件。

开放登记 — 成员有资格在每年开放登记期间登记参保。已登记参保的成员可以让自己的配偶或符合资格的家庭伴侣和您或您的配偶/伴侣所有未满 26 岁的受抚养未婚子女登记参保。

保障终止

参与者未能支付规定的月度保费或不再是 SEIU Local 503 的成员时，法律保险保障即告终止。只有在开放登记期间或保单持有人撤销保单时，才能取消计划的成员资格。已经确认承保范围的任何法律事项将继续包含在该计划中，直至该特定事项完成为止。

登记情况变更

在合格状态事件发生后的 31 天内，如果请求的更改与合格事件一致，则允许更改您的登记状态。合格状态事件可能包括：

- 结婚或离婚
- 出生或领养
- 最小的子女失去资格；例如，子女年满 26 岁或结婚
- 配偶或家属去世

您必须在合格状态事件发生后的 31 天内通知 SEIU Local 503 成员优势部门。如未能在合格状态事件发生后的 31 天内通知 SEIU Local 503 ，则下一个变更登记情况的机会是于开放登记期间。

退休

如果计划参与者退休，参与者可以作为退休人员继续在计划下受到保障，条件是该退休人员维持 SEIU Local 503 的成员资格并支付规定的月度保费。

既存病况

在保单生效日期之前发生或开始的任何法律事宜将被视为已排除在外，不适用任何保障。ARAG® 将"开始"定义为您发送或提交或收到关于法律争议的书面通知的日期；或发出票证或传票的日期；或聘请律师的日期。如果您的问题被认为是既存的，只要它不在计划的"除外情况"下列出，及只要您尚未聘请律师，您就能通过电话法律接入服务福利获得来自网络律师的建议，还能享受低于网络律师正常小时费率至少 25% 的降费法律服务。

除外情况

该法律保险计划涵盖大多数个人及消费相关法律事宜。UltimateAdvisor 概不就下列各项提供任何福利。于成员的计划生效日期之前发生或开始的任何法律事宜均将被视为除外事宜，不适用任何福利。

1. 针对 ARAG 的事宜，保单持有人（SEIU Local 503）或受保人损害同一保险凭证下的指名受保人的利益。
2. 因商业利益、投资权益、雇佣事宜、员工福利、您作为组织的高级人员或董事以及专利或版权而产生的法律服务。
3. 关于集体诉讼、判决后、惩罚性损害赔偿、不良事故、上诉、小额索偿法院或您所在州的同等法院的法律服务。
4. 被 ARAG 视为琐屑无聊或缺乏法充分理据的法律服务，或在您作为原告的诉讼中，ARAG 为您的法律服务支付的金额超过争议金额，或 ARAG 合理认为您没有积极合理地寻求您的个案的解决方案。

这是对与 ARAG® 向 SEIU Local 503 发出的保单相关的计划条文的概述。倘若本概述与保单或凭证之间出现任何抵触，保单和 / 或凭证应优先于保险条文、除外情况、所有限制和保障条款。 SEIU Local 503 可不时修订或随时全面终止该计划。

[1]美国具有 11 至 15 年工作经验的律师平均每小时的律师费为 368 美元，数据来源：The Survey of Law Firm Economics: 2018 Edition, The National Law Journal and ALM Legal Intelligence, October 2018（律师事务所经济状况调查：2018 版，《国家法律期刊》和《ALM 法律情报》，2018 年 10 月）。平均节省金额的计算基于 ARAG 内部的顶级索赔和根据 2018 ARAG 索赔数据得出的律师花费的小时数。花费的小时数乘以平均律师费率（减去 ARAG 法律计划的平均年度费用）。

[2]身份盗用保险由 Assurant 公司旗下的 American Bankers Insurance Company of Florida 承保和管理。有关条款、条件和除外情况，请参考实际保单。并非所有司法管辖区均在保险覆盖范围。请参阅保单纲要文件了解详细信息。

限制和除外情况适用。根据州法规，ARAG 法律保险计划可被视作保险产品或服务产品。保险产品由爱荷华州得梅因的 ARAG Insurance Company、爱荷华州西得梅因的 GuideOne® Mutual Insurance Company 或爱荷华州西得梅因的 GuideOne Specialty Mutual Insurance Company 承保。服务产品由 ARAG Services, LLC. 提供。本材料仅供说明，并非合同。如需了解条款、福利或除外情况，请致电 1.800.247.4184。

如需获取更多信息，请致电成员优势部门，电话号码是 1.844.503.SEIU (7348) ，或登录网站 ARAGlegal.com/plans，接入码10540sei。

LOCAL 503 SEIU Stronger Together

Legal Insurance Enrollment Form

Important notice: This form replaces all other enrollment forms on file and must be signed and dated to be valid.

Section 1 Member Information

This enrollment is for: ❍New Member ❍Open Enrollment ❍Cancel ❍Enrollment Change – *Please indicate the reason for change:*

❍Marriage ❍Death ❍Divorce ❍Other _____ Date of change _____

Name	Date of Birth	Gender ❍M ❍F	E-mail
Social Security Number	Agency Employed		Home/Cell Phone
Mailing Address	City/State	Zip	Work Phone

Marital Status ❍Single ❍Married ❍Domestic Partnership (per Certificate of Registered Domestic Partnership)
❍Widowed ❍Divorced ❍Domestic Partner (per Affidavit of Domestic Partnership)
If enrolling a domestic partner attach a completed SEIU Local 503 Affidavit of Domestic Partnership form.

Section 2 Coverage Requested *(check one - if selecting family coverage please complete Section 3)*

❍Individual ($16.29 per month) ❍Family ($21.49 per month)

Section 3 Family Plan Designation *(please list family members to be insured)*

Spouse/Domestic Partner Name

Child(ren) Name	Date of Birth	*Check if Dependent Child with a Disability**
		❑
	Date of Birth	❑
	Date of Birth	❑
	Date of Birth	❑

**See eligibility information on the reverse side of this form for dependent child with a disability who is age 26 and over.*

Section 4 Signature for Enrollment and Authorization for Payroll Deduction/Change

*I hereby apply for benefits under the SEIU Local 503 group insurance plan issued by ARAG Insurance Company. I authorize my employer to deduct from my salary the amount necessary to cover my contribution for the group coverage (if payroll deduction is available).** The amount of insurance and the premium is subject to change as determined by the master policy agreement between SEIU Local 503 and ARAG® Insurance Company. See reverse for termination of coverage information.*

Member Signature **Date**

** Please read the information on the back of this form.

FOR SEIU USE ONLY

MEMBER DATE	CODE	DEDUCTION AMOUNT	AGENCY	EFFECTIVE DATE	Policy # 10540

Please keep a photocopy for your records and mail this original to: **SEIU Local 503 at P.O. Box 12159, Salem, Oregon 97309, email to membershipadvantages@seiu503.org or fax to (503) 581-1664**

Revised for 2020 PY

保险将在执行工资扣除当月的第一天生效。如果扣除发生在某月的最后一天，则保险将于下个月的第一天生效。可能并非所有的雇主都提供工资扣除。如有任何疑问，请与您的薪资管理部门或 SEIU Local 503 成员优势办公室联系。如果工资扣除不成功，您将需要自行支付保费。

福利资格

新成员 — 在成为 SEIU Local 503 成员后 90 天内即有资格登记参保。已登记参保的成员可以让自己的配偶或家庭伴侣和您或您的配偶/伴侣所有未满 26 岁的受抚养未婚子女登记参保。如果新成员的受抚养未婚子女年龄在 26 周岁（含）以上且身体残疾，并且该成员或其配偶/家庭伴侣是他们的法院指定法定监护人，则可以让子女登记参保。必须随登记表提交法定监护权相关文件。

开放登记 — 成员有资格在每年开放登记期间登记参保。 已登记参保的成员可以让自己的配偶或家庭伴侣和您或您的配偶/伴侣所有未满 26 岁的受抚养未婚子女登记参保。

登记情况变更

只能在开放登记期间或出现合格状态事件时变更或撤销选择。您必须在合格事件发生后 31 天内通知 SEIU Local 503 成员优势办公室才有资格进行登记变更。

要继续为年满 26 周岁的受抚养未婚残疾子女提供保障，您或您的配偶/伴侣必须在该子女年满 26 周岁之前成为其法院指定的法定监护人。您必须在该子女 26 周岁生日后的 31 天内向 SEIU Local 503 成员优势部门提交法定监护权相关文件。

保障终止

参与者未能支付规定的月度保费和/或不再是 SEIU Local 503 的成员时，该法律计划下的保障即告终止。

如果参保者退休，则该参保者可以作为退休人员继续在计划下受到保障，条件是该退休人员维持 SEIU Local 503 的成员资格并支付规定的月度保费。

SEIU Local 503 可不时修订或随时全面终止该计划。

既存病况及持续保障

在保单生效日期之前发生或开始的任何法律事宜将被视为已排除在外，不适用于任何福利。ARAG® 将"开始"定义为您发送或提交或收到关于法律争议的书面通知的日期；或发出票证或传票的日期；或聘请律师的日期。

已经确认承保范围的任何法律事项将继续包含在该计划中，直至该特定事项完成为止。

请记住，只有保险单能提供实际的条款、保障范围、金额、条件及除外情况。

SEIU Local 503
PO Box 12159
Salem, Oregon 97309-0159

1.844.503.SEIU (7348)

定期寿险资格

如果您是成员且每月工作至少 40 小时，您就有资格申请成员自愿性定期寿险。

家属

您的配偶

如果您已经登记为自己投保，您的合法配偶就有资格申请。

您的同居伴侣

如果您已经登记为自己投保，且你们的关系符合 SEIU Local 503 同居伴侣誓章（请见第 16 页）上的标准，或者您已取得俄勒冈州同居伴侣关系证明，则您的同居伴侣有资格申请。

您抚养的子女

如果您已登记参加保险，您未满 26 岁的子女如果未婚、未处于同居伴侣关系且满足以下任一标准，就符合参保资格：

1. 您或您配偶的亲生子女、继子女、领养子女或在法律上由您或您配偶领养的子女；或
2. 您或您配偶对其具有法院指定的监护权的子女；或
3. 您或您配偶须通过合法的合格医疗支持令向其提供保障的子女。

如果在保障开始日期，您的配偶 / 伴侣或子女无法执行其年龄和性别的一般日常生活活动，则在他或她能够执行这些活动之前，他或她的保障不会开始。

成员定期寿险

提供以下几种金额的成员自愿性定期寿险：**10,000 美元、20,000 美元、30,000 美元、40,000 美元、50,000 美元、60,000 美元、70,000 美元、80,000 美元、90,000 美元、100,000 美元、110,000 美元、120,000 美元、130,000 美元、140,000 美元、150,000 美元、160,000 美元、170,000 美元、180,000 美元、190,000 美元或 200,000 美元**

新成员 — 如果您在成为 SEIU Local 503 成员后的 90 天内登记，则有资格投保以下金额：**10,000 美元、20,000 美元、30,000 美元、40,000 美元、50,000 美元、60,000 美元、70,000 美元、80,000 美元、90,000 美元或 100,000 美元**

开放登记 — 您有资格投保以下金额：**10,000 美元、20,000 美元、30,000 美元、40,000 美元、50,000 美元**

任何其他时间的登记和所有其他金额的登记都需要令人满意的可保性证明及 LifeMap Assurance Company 的批准。

配偶 / 伴侣定期寿险

提供以下几种金额的配偶/伴侣自愿性定期寿险：**10,000 美元、20,000 美元、30,000 美元、40,000, 50,000 美元、60,000 美元、70,000 美元、80,000 美元、90,000 美元、100,000 美元、110,000 美元、120,000 美元、130,000 美元、140,000 美元、150,000 美元、160,000 美元、170,000 美元、180,000 美元、190,000 美元或 200,000 美元**

新成员 — 如果您在成为 SEIU Local 503 成员后的 90 天内登记并自己选择保险金额，则您的配偶/伴侣有资格投保以下金额：**10,000 美元、20,000 美元、30,000 美元或 40,000 美元**

开放登记 — 如果您自己选择投保金额，则您的配偶/伴侣有资格投保以下金额：**10,000 美元或 20,000 美元**

任何其他时间的登记和所有其他金额的登记都需要令人满意的可保性证明及 LifeMap Assurance Company 的批准。

子女定期寿险

提供以下几种金额的子女自愿性定期寿险：5,000 美元或 10,000 美元

新成员 — 如果您在取得新的 SEIU Local 503 成员资格后 90 天内登记，且您选择为自己投保，则您的子女有资格投保以下金额：**5,000 美元或 10,000 美元**

开放登记 — 如果您已登记，则可以保证您的子女登记以下金额：**5,000 美元或 10,000 美元**

任何其他时间的登记都需要令人满意的可保性证明及 LifeMap Assurance Company 的批准。

末期疾病福利
如果您被医生诊断为患有末期疾病，预期寿命只有 12 个月或更短，末期疾病提前给付将向受保人提供有效保障金额的 80% 或 120,000 美元（以较低者为准）。

在末期疾病福利下支付任何福利均将导致自愿性寿险的身故福利降低，且有可能须缴税。就税务事项而言，您应咨询个人税务顾问，以评估此项福利的影响。

除外情况
自愿性定期寿险概不就保障首两年内于精神正常或失常时因自杀、故意自残或任何企图自我伤害而导致的死亡进行赔付。

年龄增长调整
SEIU Local 503 会根据您的出生年份调整您及您家人定期寿险保障的月度保费金额。调整发生在您进入下一年龄范围后的第一个月。

保费豁免
如果您完全残疾（定义见保单），保费将被豁免，自愿性定期寿险福利将持续，直至成员年满 65 岁，前提是您一直完全残疾。

转换特权
当您终止雇佣关系时，您的定期人寿保险将在 31 天内免费继续。在此期间内，您可将自愿性定期寿险福利转换为有保证的个人永久保单。团体保障的转换申请必须在雇佣终止后 31 天内提出。

可携性特权
如果您在年满 65 岁之前终止雇佣关系，自愿性定期寿险福利可以转移。配偶 / 伴侣及子女的寿险也可以转移。您必须自您终止受雇日期起 31 天内提出申请。保险覆盖范围是有保证的。

短期残疾保险资格

如果您是成员及每月工作至少 80 小时，则您有资格申请成员短期残疾保险。

短期残疾保险

如果您由于非工作时间的意外职外身体伤害或疾病致残而无法工作，则您将因承保的残疾险获付最高 26 周的每周福利金。您不必住院或在家休养，才有资格获得相关福利。您须经医师认证无法工作，并须接受医师护理。**为让您的保障生效，您须于保险生效日期在职工作。**

残疾福利
- 对于非工作时间的**事故**，保障于持续及完全残疾的第 15 日起计。您的残疾须经执业行医的治疗医师核证。
- 对于非工作时间的**疾病**，保障于持续及完全残疾的第 15 日起计。您的残疾须经执业行医的治疗医师核证。

残疾定义
如果您因为伤害或疾病而无法履行您常规职业的所有重大职责，则您将被视为残疾。

新成员 — 您可于成为新成员后的 90 天内登记短期残疾保险，而无须提供可保性证明。

开放登记 — 您可在年度开放登记期，登记短期残疾保险。

您可通过回答可保性证明表格中的健康问题，随时登记短期残疾保险。保障将在经保险公司批准后发出。保障将在经保险公司批准后生效，届时将支付保费。

短期残疾保险福利金额

第 1 类：如果您每月基本收入为 999 美元或以下，且每月至少工作 80 小时。则您在残疾期间各周的每周福利金为 175 美元。

第 2 类：如果您每月基本收入为 1,000 美元至 2,999 美元，且每月至少工作 80 小时。则您在残疾期间各周的每周福利金为 225 美元。

第 3 类：如果您每月基本收入为 3,000 美元至 3,999 美元，且每月至少工作 80 小时。则您在残疾期间各周的每周福利为您薪水的 66 2/3% ，最高为 300 美元。

第 4 类：如果您每月基本收入为 4,000 美元或以上，且每月至少工作 80 小时。则您在残疾期间各周的每周福利金为您薪水的 66 2/3% ，最高为 500 美元。

除外情况

如果您的残疾直接或间接因下列各项而产生，则将不会支付短期残疾福利：

a) 蓄意招致的伤害，不论神智是否正常；或
b) 已宣布或未宣布的战争的任何作为或损害；或
c) 积极参与暴乱；或
d) 犯重罪；或
e) 您有权因此享有工伤赔偿 (Workers' Compensation) 福利或职业疾病法规定提供的福利的伤害或疾病；或
f) 工作相关的伤害或疾病。

若您未接受执业医师在执业范围内进行的适当护理，则您无法在残疾期间获付短期残疾福利。

既存病况的限制

如果在您保障的首 12 个月内出现的残疾是因既存病况所致，您则不会获支付短期残疾福利。既存病况是指您在短期残疾保险生效日期前 3 个月内，因此曾接受任何类型治疗（包括处方药）的疾病或伤害。

这是 LifeMap 向 SEIU Local 503 发出的保单相关计划条文概要。倘若本概述与保单或凭证之间出现任何抵触，保单和 / 或凭证应优先于保险条文、除外情况、所有限制和保障条款。

如何登记

新成员登记

您须填写及提交 SEIU Local 503 定期人寿及残疾登记表。如果您登记超过保证金额的保障，则您须填写及提交可保性证明表格。请阅读整个册子，了解登记规定。 SEIU Local 503 成员优势部门须在 90 天内受理新工会成员的填妥表格。

开放登记

您须填写及提交 SEIU Local 503 定期人寿及残疾登记表。如果您要登记超过保证金额的保障，则须填写及提交可保性证明表格。请阅读整个册子，了解登记规定。SEIU Local 503 成员优势部门须在开放登记最后一天之前受理填妥的表格。

登记情况变更

若出现合格状态事件，则可变更您的计划，及若所请求的变更符合合格事件，则在事件发生的 31 天内变更。合格状态事件可能包括：

- 结婚或离婚
- 出生或领养
- 最小的子女丧失保障，如子女年满 26 岁或结婚
- 配偶或家属去世

成员和配偶月度寿险保费

（配偶保费根据成员的年龄计算）

成员年龄	每 10,000 美元保额的月费
25 岁以下	$0.81
25-29	$0.76
30-34	$0.88
35-39	$1.18
40-44	$1.73
45-49	$2.68
50-54	$4.25
55-59	$6.65
60-64	$9.34
65-69	$16.63
70-74	$32.99
75 岁及以上	$67.96

成员短期残疾月度保费

（根据每月总工资分类）

薪水分类	每周福利	每月费率
第 I 类（月薪低于 999 美元）	$175	$8.58
第 2 类（月薪 1,000 美元至 2,999 美元之间）	$225	$11.03
第 3 类（薪水 3,000 美元至 3,999 美元之间）	$300	$14.70
第 4 类（薪水 4,000 及以上）	$500	$24.50

儿童保费

（一个费率适用于所有符合条件的儿童）

儿童费率	$5,000	$10,000
所有年龄	$0.80	$1.60

请使用下方的公式计算您的月度保费：

第 1 步 — 成员保费

[ ] 预期福利 ÷ 10,000 x [ ] 费用（来自上表） = [ ] 月度保费

第 2 步 — 配偶保费

[ ] 预期福利 ÷ 10,000 x [ ] 费用（来自上表） = [ ] 月度保费

第 3 步 — 子女保费

[ ] 预期福利 [ ] 费用（来自上表） = [ ] 月度保费

第 4 步 — 短期残疾

[ ] 预期分类 [ ] 费用（来自上表） = [ ] 月度保费

添加月度总计对应的所有保费： [ ] 月度保费总计

如何计算您的月度保费

第 1 步 — 确定成员月度寿险费率
从"成员和配偶寿险保费"表中查找到正确的费率（该费率根据**成员的**年龄计算）。*费率针对的是金额为 10,000 美元的保险。用费率乘以所选的保障金额。例如：年龄为 31 岁的成员选择了 50,000 美元的保障金额（月度保费计算公式则为 50,000 美元 ÷ 10,000 美元 = 5 x 0.88 = 4.40 美元）*

第 2 步 — 确定配偶月度寿险费率
从"成员和配偶寿险保费"表中查找到正确的费率（该费率根据**成员的**年龄计算）。*费率针对的是金额为 10,000 美元的保险。用费率乘以所选的保障金额。例如：年龄为 31 岁的成员选择了 50,000 美元的保障金额（月度保费计算公式则为 50,000 美元 ÷ 10,000 美元 = 5 x 0.88 = 4.40 美元）*

第 3 步 — 确定子女寿险保费
从"子女寿险保费"表中找到正确的费率。

第 4 步 — 确定成员短期残疾保费
选择预期的每周收益。薪资分类决定了根据您的月度工资可选择的最大收益（可选择较低工资分类）。费率根据税前月度工资（总工资）计算。

第 5 步 — 将所有保费相加。这将确定您的月度总保费。

如需其他信息或在计算保费时需要帮助，请致电成员优势部门，电话：1.844.503.SEIU (7348)。

本资料简要描述了本计划的重要特点，并非合同。定期人寿保障的条款和条件载于团体保单号 OR 048692。短期残疾保障的条款和条件载于团体保单号 OR 048692。本要约的可得性可能发生变动。如您投保，则请将本材料留作参考，及与您的证书一同存档。

SEIU Local 503 可不时修订或随时全面终止该计划。

承保人
LifeMap Assurance Company

LOCAL 503 SEIU
Stronger Together

Term Life, Disability & Beneficiary Enrollment Form

Important notice: This form replaces all other enrollment forms on file and must be signed and dated to be valid.

Section 1 Member Information

This enrollment is for: ❍ New Member ❍ Open Enrollment ❍ Cancel ❍ Beneficiary Designation Only ❍ Change-Qualifying Event _____ Date of Event _____

Name	Date of Birth	Gender ❍M ❍F	E-mail

Social Security Number	Agency Employed	Home/Cell Phone

Mailing Address	City/State	Zip	Work Phone

Marital Status ❍Single ❍Married ❍Domestic Partnership (per Certificate of Registered Domestic Partnership) ❍Widowed ❍Divorced ❍Domestic Partner (per Affidavit of Domestic Partnership)

If enrolling a domestic partner attach a completed SEIU Local 503 Affidavit of Domestic Partnership form.

How many hours per month do you work in your SEIU Local 503 represented position? _____

☑ **Free $2,500 Member Term Life**

Section 2 Voluntary Term Life Insurance *(you must work at least 40 hours per month to enroll in life insurance)*

Member Voluntary Term Life [1]

(Member term life benefit levels are $10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000 , $100,000, $110,000, $120,000, $130,000, $140,000, $150,000, $160,000, $170,000, $180,000, $190,000 or $200,000)

❍$10,000, ❍$20,000, ❍$30,000, ❍$40,000, ❍$50,000

❍Other Amount (max. $200,000) $ _____

Child Voluntary Term Life [3]

❍$5,000 or ❍$10,000

Child Name	Date of Birth	Relationship

Spouse/Partner Voluntary Term Life [2, 3]

(Spouse term life benefit levels are $10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000 , $100,000, $110,000, $120,000, $130,000, $140,000, $150,000, $160,000, $170,000, $180,000, $190,000 or $200,000)

❍$10,000, ❍$20,000, ❍$30,000, ❍$40,000

❍Other Amount (max. $200,000) $ _____

Spouse/Partner Name	Date of Birth	Relationship

[1] *Member Voluntary Term Life-new member (within 90 days of new SEIU membership) guaranteed up to $100,000 - open enrollment guaranteed up to $50,000*

[2] *Spouse Voluntary Term Life-new member (within 90 days of new SEIU membership) guaranteed up to $40,000 - open enrollment guaranteed up to $20,000*

[3] *You must be enrolled in voluntary member term life to apply for spouse/partner or child term life.*

Section 3 Voluntary Short Term Disability Insurance *(you must work at least 80 hours per month to enroll in short term disability insurance)*

Short Term Disability Insurance: $ _____ *(current monthly salary)*

Monthly Salary: ❍Class 1 *up to $999* ❍Class 2 *$1,000-$2,999* ❍Class 3 *$3,000-$3,999* ❍Class 4 *$4,000 and up*

Section 4 Beneficiary Designation *(attach an additional sheet if more space is required. Additional sheet must be signed and dated to be valid)*

You may choose a beneficiary(s) to receive life benefits. If no beneficiary survives, payment will be made in accordance with the terms of the policy. Unless designated otherwise, beneficiary designations for all life coverage will be the same. For Spouse/Partner and Child Term Life, you are the beneficiary.

	Name of Beneficiary	Social Security #	Date of Birth	Address	Relationship
Primary					
Contingent					

Section 5 Signature for Enrollment , Beneficiary Designation and Authorization for Payroll Deduction

I (we) request to be insured and authorize payroll deductions to cover the cost of coverage (if payroll deduction is available)*. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance Effective Date; and (b) all insurance is subject to the eligibility provisions of the Policy; and (c) I must be Actively at Work (as defined in the Group Policy) to be insured. If I am not Actively at Work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

Signature _____ **Date** _____

Please read the information on the back of this form.

FOR SEIU USE ONLY

MEMBER DATE	CODE A M S C D	DEDUCTION AMOUNT	AGENCY	EFFECTIVE DATE	GWNN

Please keep a photocopy for your records and mail this original to: **SEIU Local 503 at P.O. Box 12159, Salem, Oregon 97309, email to membershipadvantages@seiu503.org or fax to (503) 581-1664**

Revised for 2020 PY

保险将于工资扣除当月的第一天生效。如扣除发生在某月的最后一天，则保险将于下一个月的第一天生效。* 工资扣减可能不适用于所有员工。如有任何疑问，请联系您的薪资部门或 SEIU Local 503 会员优势办公室。如不能进行工资扣除，您将需要自行支付保费。

入保资格：
要获得本计划的保险资格，您必须维持您在 SEIU Local 503 的成员资格。您须每月于您的 SEIU Local 503 代表职位工作至少 40 小时，方可购买寿险。您须每月于您的 SEIU Local 503 代表职位工作至少 80 小时，方可购买短期残疾保险。您须满足最低规定时数并在职工作，才可令您的保险生效。

有资格获得保障的家属包括配偶 / 伴侣及所有未满 26 岁的未婚受抚养子女。如果登记同居伴侣，则附上填妥的同居伴侣宣誓书表格，或在本表格正面指明您已获得注册同居伴侣证书。

如果家属在其保障日期无法履行与其年龄及性别相同的人士所履行的常规活动，则其须在完成上述活动之后，方可获得保障。

登记和保费变更

仅可在开放登记期或发生合格状态事件时变更或取消登记选择。您必须在合格事件发生后 31 天内通知 SEIU Local 503 成员优势办公室才有资格进行登记变更。将依据 LifeMap Assurance Company 发布的福利手册和主保单所载列薪水和年龄表变更保险金额和保费。

保障终止

若参与者未能支付规定的月度保费付款，或不满足资格规定及 / 或不再是 SEIU Local 503 的成员，则定期寿险计划下的保障将终止。

若计划参与者退休或终止雇佣，则寿险将免费持续 31 天。在该期间，您可将您的自愿定期寿险转换成个人担保的永久保单。须在退休或终止雇佣后的 31 天内申请转换。您有责任联系 SEIU Local 503 的成员优势办公室，请求转换申请。

如果计划参与者在 65 岁前终止雇佣，则自愿定期寿险福利可具有可携带性。您必须自您终止受雇日期起 31 天内提出申请。您有责任联系 SEIU Local 503 的成员优势办公室，请求可携性申请。

福利资格和终止条文详载于 LifeMap Assurance Company 福利手册。该手册位于 SEIU Local 503 网站 seiu503.org，点击成员优势**页面**。您可拨打下列号码，联系 SEIU Local 503 成员优势办公室，获取手册的打印本。

SEIU Local 503 可不时修订或随时全面终止该计划。

SEIU Local 503
PO Box 12159
Salem, Oregon 97309-0159

1.844.503.SEIU (7348)

LifeMap™ P.O. Box 1271 MS E8L
Portland, OR 97297-1271

Mail to:
SEIU Local 503
P.O. Box 12159
Salem, OR 97309

LOCAL 503 SEIU Stronger Together

Evidence of Insurability Form

Part I

This box for SEIU use only:

Existing Voluntary Coverage: Member $ _____ Spouse/Domestic Partner (DP) $ _____ Child(ren) $ _____ Verified _____

Applying for:
○ Supplemental Life ○ STD Class _____

Total Amount of Insurance requested (Show existing PLUS any increase)
Member $ _____ Spouse/DP $ _____ Child(ren) $ _____

Member Name | Phone Number

Residence Address Street | City | State | Zip Code

Social Security Number – – | Birthdate Mo Day Yr / / | Gender M F | Place of Birth | Annual Salary $

Name of organization providing insurance: **SEIU Local 503** | Policy Number: **OR 048692** | Occupation | Date of Employment

Spouse / DP Name (if applying for coverage) | Social Security Number – – | Birthdate Mo Day Yr / / | Gender M F | Place of Birth

Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance Effective Date; and (b) all insurance is subject to the eligibility provisions of the Policy; and (c) I must be Actively at Work (as defined in the Group Policy) to be insured. If I am not Actively at Work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

To help ensure efficient processing, mail, fax or email the completed form to: LifeMap Assurance Company, P.O. Box 1271, M/S E8L, Portland, OR 97207 or Fax (855) 854-4570 or Email: Billing@LifeMapCo.com

STATE FRAUD WARNING STATEMENTS

For residents of 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.

For your protection California law requires the following statement to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

NOTICE OF INFORMATION PRACTICES
Please read and keep a copy for your records.

In the course of properly underwriting and administering your insurance coverage, LifeMap Assurance Company will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, MIB Inc., and other insurance companies.

Information regarding your insurability will be treated as confidential. LifeMap Assurance Company or its reinsurers may, however, make a brief report to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA, 02184-8734 or they can be reached by email at infoline@mib.com.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: LIFEMAP ASSURANCE COMPANY, ATTN: INDIVIDUAL UNDERWRITING, 200 SW MARKET STREET, P.O. Box 1271, M/S E8L, PORTLAND, OR 97207

X _____ _____ **X** _____ _____

Member Signature | **Date Signed** | **Spouse / DP (if applying for coverage)** | **Date Signed**

(Please complete all four pages of this form.)

LifeMap Assurance Company®
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800) 794-5390 | Fax (855) 854-4570
Email: Billing@LifeMapCo.com

LifeMap Evidence of Insurability Form

(Part 2 of the Voluntary Benefits Application)

Section 1: Applicant Information. Please complete using dark ink.

Employee's Name (Last, First MI)				
Social Security Number	Date of Birth	Height: ____Ft.____ In.	Weight: _____ lbs	☐ M ☐ F
Spouse Name (If applying for coverage)				
Social Security Number	Date of Birth	Height: ____Ft.____ In.	Weight: _____ lbs	☐ M ☐ F
Dependent Child Name (If applying for coverage)	Date of Birth	Height: ____Ft.____ In.	Weight: _____ lbs	☐ M ☐ F
Dependent Child Name (If applying for coverage)	Date of Birth	Height: ____Ft.____ In.	Weight: _____ lbs	☐ M ☐ F

If you have additional eligible children, please attach a sheet showing their information.

Section 2: Health Questions

Each Applicant must answer each of the following questions to the best of their knowledge and belief. A legal guardian is required to answer each of the questions for minor children.

	Employee	Spouse	Child(ren)
1. Within the past 2 years have you or your spouse, if applying for coverage, used cigarettes or other tobacco products?	☐ Y ☐ N	☐ Y ☐ N	
2. Within the past 5 years has any person applying for coverage been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
3. Within the past 5 years has any person applying for coverage been diagnosed with, received medical care, or taken medication for a disease or disorder of any of the following:			
a. **Cardiac or Cardiovascular** (such as Heart Disease, High Blood Pressure, Atherosclerosis, Coronary Artery Disease, Heart Attack, Chest Pain, Heart Murmur or Palpitations, Cardiomyopathy, Heart Valve Disorder or Heart Failure)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
b. **Circulatory** (such as Stroke, Transient Ischemic Attack (TIA) or High Cholesterol)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
c. **Blood** (such as Anemia, Leukemia, Multiple Myeloma or Thrombocytosis)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
d. **Endocrine** (such as Diabetes, Thyroid, Adrenal or Pituitary Disorder)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
e. **Respiratory** (such as Asthma, COPD, Emphysema or Cystic Fibrosis)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
f. **Kidney, Urinary Tract or Prostate** (such as Proteinuria or PSA Abnormality)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
g. **Gastrointestinal or Liver** (such as Hepatitis, Colitis, Diverticulosis, Crohn's Disease, Pancreatitis, Ulcer or Decreased Liver Function)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
h. **Autoimmune or Connective Tissue** (such as Lupus, Rheumatoid Arthritis, Scleroderma, Multiple Sclerosis or Mixed Connective Tissue Disease)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
i. **Nervous, Mental or Emotional** (such as Anxiety, Depression, Memory Loss, Schizophrenia, Mood Disorder or Attempted Suicide)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

EMPLOYEE'S NAME:

	Employee	Spouse	Child(ren)
j. **Neurological or Central Nervous** (such as Epilepsy, Seizure, Dizziness, Motor Neuron Disease, ALS, Muscular Dystrophy, Cerebral Palsy, Paralysis or Parkinson's Disease)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
k. **Musculoskeletal** (such as Arthritis, Osteoarthritis, Degenerative Disc or Joint Disease, Carpal Tunnel, or Knee, Hip, Shoulder or Other Joint Condition)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
4. Within the past 5 years has any person applying for coverage been diagnosed with, received medical care, or taken medication for any of the following:			
a. **Cancer, Hodgkin's Disease, Lymphoma, Malignant Growth or Tumor?**	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
b. **Epstein Barr, Chronic Fatigue Syndrome or Fibromyalgia?**	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
c. **Alcohol, Drug or Substance Abuse?**	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
5. Has any person applying for coverage been advised or recommended by a physician to have surgery or a test or evaluation which has not yet been performed? (except pregnancy or orthopedic)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
6. Within the past 5 years has any person applying for coverage had a condition that has lasted for 3 months or more for which care or treatment was recommended or received or for which medication was prescribed by a physician or health care provider?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
7. Is any person applying for coverage disabled or does any person applying for coverage have a condition which prevents or limits activities?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8. Are you currently pregnant? If yes, anticipated due date (MM/DD/YY): _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
9. During the past 5 years have you been absent from work for more than five consecutive working days because of your own illness or injury (excluding pregnancy)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Provide details of all 'YES' answers given to the health questions in Section 2.
If additional space is required, attach a separate signed and dated sheet.

Question Number	Individual	Illness/Reason for Checkup or Physician's Treatment/Consultation	Dates From - To	Full Name & Complete Address of Attending Physician or Other Practitioner

Section 3: Authorization to Disclose Personal Information & Application for Insurance.
I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, MIB Inc., insurance company or other organization, institution or person that has any records or knowledge of me or my health, gathered during the course and scope of their business, to give the LifeMap Assurance Company or its reinsurers any such information, including information about drug or alcohol use or abuse, mental illness, AIDS virus or other sexually transmitted diseases (with the exception of HIV records), in connection with prior testing for the purpose of obtaining insurance. This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received a copy of the Privacy Notice.

IMPORTANT: Please continue completing form on the following page.

EMPLOYEE'S NAME:

Section 4: Authorization to Disclose Protected Health Information.
I authorize any physician, pharmacy benefit manager, retail pharmacy, clearing house, health plan or insurance company to disclose prescription drug information about me within their possession to Milliman IntelliScript on behalf of LifeMap Assurance Company ("LifeMap"). The purpose of this disclosure is for Milliman to provide the information to LifeMap to evaluate my application for Life, Disability, and/or Critical Illness insurance products.

I understand that this prescription drug information may contain sensitive data, including data related to the treatment of sexually transmitted diseases, HIV/AIDS, mental health and reproduction or contraception (including prenatal care and abortion). I specifically authorize the disclosure of prescription drug information that is related to alcohol or substance abuse and I understand that my alcohol and substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described below.

I understand and acknowledge the following:

- I may cancel this authorization at any time by sending written notice to LifeMap Assurance Company, Attn: Individual Underwriting, PO Box 1271 M/S E8L, Portland, OR 97207. Cancellation of this authorization will not (1) affect any actions taken by any entity disclosing information before receiving the cancellation notice or (2) be effective with respect to any reliance on the authorization to contest a claim or the policy itself, to the extent permitted by applicable law.
- Completing this authorization is a condition to be eligible for and enrolled in LifeMap Life, Disability and/or Critical Illness insurance products.
- The physicians, pharmacy benefit managers, retail pharmacies, clearinghouses, health plans, and insurance companies identified above will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.
- Once any person(s) or entity(ies) discloses my information to an authorized recipient the information could be subject to redisclosure by the recipient and the privacy protections provided by law may no longer apply. Please see LifeMap's Privacy Notice for information on how LifeMap protects the confidentiality of your personal information.
- None of the authorized person(s) and entity(ies) above nor Milliman are responsible for any action taken by an authorized recipient of my protected health information.
- This authorization will expire six (6) months from the date of signature.

THIS FORM IS NOT VALID UNTIL SIGNED AND DATED BY ALL APPLICANTS.

Unless specific state language is provided on Page 4, the following general fraud notice applies: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

By signing below, **each** proposed insured(s) agrees to the following:

1) I agree with all the terms, conditions, statements, and representations stated above in Section 1: Applicant Information, Section 2: Health Questions, and,

2) I agree to the authorization in Section 3: Authorization to Disclose Personal Information & Application for Insurance, and Section 4: Authorization to Disclose Protected Health Information.

3) Information in this form is given to obtain insurance, and the statements and answers are represented, to the best of my knowledge and belief, to be true and complete. I understand that the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance Effective Date; and (b) all insurance is subject to the eligibility provisions of the Policy; and I must be Actively at Work (as defined in the Group Policy) to be insured. If I am not Actively at Work on the date my coverage would become effective, my coverage will not begin until the day I return to work.

4) If my answers on this application are incorrect or untrue, LifeMap Assurance Company has the right to deny benefits or rescind my coverage for up to two years from the date coverage becomes effective.

▶ _____ ▶ _____
EMPLOYEE Signature — Date Signed

▶ _____ ▶ _____
SPOUSE Signature (if applying for coverage) — Date Signed

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individuals (e.g., Power of Authority, Guardianship, Conservatorship, Etc.)

_____ _____ _____
Name of Personal Representative — Relationship — Phone Number

▶ _____ ▶ _____
PERSONAL REPRESENTATIVE Signature — Date Signed

SEIU LOCAL 503
MEMBERSHIP ADVANTAGES
AFFIDAVIT OF DOMESTIC PARTNERSHIP

SECTION ONE - AFFIRMATION OF DOMESTIC PARTNERSHIP

(1) Are each eighteen (18) years of age or older.

(2) Share a close personal relationship and are responsible for each other's common welfare.

(3) Are each other's sole domestic partner.

(4) Are not married to anyone nor have had another domestic partner within the prior six months.

(5) Are not related by blood closer than would bar marriage in the State of Oregon.

(6) Have jointly shared the same regular and permanent residence for at least six (6) months immediately preceding the date of this affidavit with the intent to continue doing so indefinitely.

(7) Have signed a domestic partner declaration (applicable in jurisdictions, which provides for domestic partner declarations).

(8) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost. If requested I would be able to provide at least three of the following as verification of our joint responsibility.

(a) Joint mortgage or lease.
(b) Designation of the domestic partner as primary beneficiary for a life insurance or a retirement contract.
(c) Designation of the domestic partner as primary beneficiary in the employee's will.
(d) Durable power of attorney for health care or financial management.
(e) Joint ownership of a motor vehicle, a joint checking account, or a joint credit account.
(f) A relationship or cohabitation contract which obligates each of the parties to provide support for the other party.

SECTION TWO - DECLARATION OF MEMBER

(1) I understand that my domestic partner is eligible for enrollment:

(a) Within 90 days of my becoming a new member of SEIU Local 503.
(b) During an open enrollment period.
(c) Within 31 days of meeting the criteria listed in Section One.

(2) I understand that children of my domestic partner are eligible if they meet the requirement for an eligible dependent as defined by LifeMap Assurance Company, and/or ARAG Group.

(3) I understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in circumstance attested to in this Affidavit.

(4) I agree to file a Statement of Termination of Domestic Partnership with the SEIU Local 503 Membership Advantages office within 30 days of any change to circumstances attested to in this Affidavit.

(5) After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed with the SEIU Local 503 Membership Advantages until such time as the conditions of Section One above have been met.

SECTION THREE - DECLARATION OF PARTNERS

(1) We understand that the information contained in the Affidavit relates to eligibility for benefits under the SEIU Local 503 life and/or legal insurance program. Any other use of this information will be subject to disclosure only upon either of our written authorization or as required by law.

(2) We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Affidavit of Domestic Partnership.

(3) We understand that in addition to the eligibility requirements of SEIU Local 503 Membership Advantages program for domestic partner coverage, there are terms and conditions of coverage set forth in the Service Agreement of each insurance plan offered through SEIU Local 503, plans which we agree to be bound.

(4) We understand willful falsification of information contained in this Affidavit will result in termination of enrollment pursuant to this agreement by the SEIU Local 503 Membership Advantages program.

We certify under penalty of perjury under the laws or the State of Oregon, that the foregoing is true and accurate to the best of our knowledge

Signature of Member	Print Name
Signature of Domestic Partner	Print Name
Member SSN	Date

This affidavit of domestic partnership is for SEIU Local 503 life and/or legal insurance enrollment only and must be received by the SEIU Local 503 Membership Advantages office to be valid.

Fax completed enrollment forms and domestic partner affidavit to (503) 581-1664 , mail to SEIU Local 503, PO Box 12159, Salem , OR 97309-0159 or e-mail to membershipadvantages@seiu503.org.

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800) 794-5390

隐私声明

我们， LifeMap Assurance Company 知道您重视您的隐私。这也是我们致力于保障您个人信息的机密性及安全的原因。由于我们竭力赢得及维持您的信任，我们设有长期隐私政策、稳健的培训及致力于保护隐私的全职员工。我们还设有保障您个人信息免遭未经授权查阅的实体、行政及技术保障措施。您的资料仅限我们组织内部须获知有关信息以向您提供服务或开展我们业务的人士查阅。即便您不再是 LifeMap 成员，我们仍将保障您个人信息的机密性，如同您是我们的成员一般。

市场营销

尽管其他公司可能出售或租赁您的联系信息，但是 LifeMap 绝不会出售或租赁您的个人信息用于营销目的。如果您想要 LifeMap 与非联属第三方分享您的个人信息，以便第三方可向您营销，则您必须向我们给出明确同意。

您的个人信息

我们向您、您的供应商和向您提供保障的其他保险公司收集您的姓名、联系信息、健康信息及财务信息等个人信息。我们使用该信息以向您提供服务及开展保险业务。除非法律批准或要求或您同意，否则我们不会披露您的个人信息。若法律批准或要求，我们可能向我们的联营公司和代理、再保公司、保险管理者、顾问或监管和政府当局提供个人信息。我们促使代表我们收取该信息的实体以我们保护该信息的方式保护该信息。

查阅和纠正您的个人信息

您可请求获取您个人信息的副本，以检查该信息的完整性和准确性。按您要求向下列诊所发送的隐私询问必须以书面形式作出。请纳入您的姓名、诊所和保单号码并对您的签名进行公证。上述各项旨在保护您，且可让我们证明您的身份。

若法律要求，我们将纠正或修订我们备存的个人信息。如果我们对于相关记录不准确表示不赞同，则您可要求我们在您的文档中添加反驳声明。

我们实务的变更

我们可变更我们的隐私实务，以提供更佳的保障。如果我们重大变更我们的隐私实务，则我们将书面通知目前的客户。

联系我们

如果您对我们的隐私计划有任何疑问，您可拨打 (800) 794-5390 或致函

LifeMap 隐私官员，联系我们
P.O. Box 1271, Mailstop E12P
Portland, OR 97207

成员优势

Aflac 成员可通过 Aflac 获得保单续保，包括意外、医院赔偿、牙科和癌症/定向疾病保险。这些福利是预先确定的，且在您已有的其他保险外赔付。

按揭、购房、教育/资源 SEIUMB 为成员按揭购房和再融资计划提供有竞争力的利率和专享折扣。Resident Lending Group 专门从事指导买房者开展买房流程。 他们提供传统、专业及"新颖"的按揭。

Auto & Home Insurance成员可按特别费率和折扣保护他们的汽车和房屋。

Bright Now! Dental 成员及其家人有资格通过参与的 Bright Now! Dental 诊所获得优惠牙科服务。无牙科保险的成员最多可在大部分牙科手术上节省 35%。有牙科保险的成员在 Bright Now! Dental 办事处访诊时可最大程度地享有现行牙科福利。

宠物保险通过购买宠物险帮助向您的宠物提供最佳护理。

俄勒冈处方药计划成员可在俄勒冈州享有俄勒冈**处方药计划 (OPDP)**。无健康保险或有健康保险但是可以使用帮助支付处方药的成员可通过 OPDP 利用可用的折扣价。

Great Wolf Lodge 成员将最高获得其最佳费率的七折优惠。

奖学金计划 SEIU Local 503 向活跃成员、其配偶、其同居伴侣、子女和孙子女提供两种一年期奖学金奖励。

Motivano SmartSavings 成员可获得在线折扣。折扣范围包括旅行、租车、手机、主题公园、餐馆等。

Northwest Community Credit Union 成员将在于 Northwest Community Credit Union 开立新账户时，获得特别优惠。

SEIUMB 成员及其家人可享有 SEIU INTERNATIONAL 的福利计划。成员可享受独家折扣、财务服务及免费和低成本线上大学等教育福利。

退休策略和教育财务挑战可能令您难以达成您的目标。退休规划将帮助您了解资金如何运作，及找到最适合您退休需求的产品和服务。免费向 503 地方分会成员提供财务等级和财务审核，而无须支付成本或承担债务。*通过 Transamerica Financial Advisers, Inc. (TFA) Member FINRA, SPIC 和注册投资顾问 TFA97880-0918 提供证券和投资咨询服务。*

Sunrise Dental 无牙科保险的 成员可通过 Sunrise Dental 诊所获得牙科服务折扣。有牙科保险的成员可获得新患者信贷。

欲知如何获得成员优势的相关信息，请参阅下页的目录。

成员优势

Aflac 欲知有关登记信息，请拨打免费电话 1.855.734.8503。

Bright Now! Dental 如需获取参与地点的清单，请登录网站 brightnow.com 或发送电子邮件至 robert.etulain@smilebrands.com。

宠物保险 欲知宠物保险相关信息，请发电邮至 membershipadvantages@seiu503.org 或拨打电话 1.844.503.SEIU (7348)，联系成员优势办公室。

俄勒冈处方药计划登录网站 oregon.gov/oha/hpa/csi-opdp，获得俄勒冈处方药折扣卡。

法律保险若有登记相关问题，请发电子邮件至 membershipadvantages@seiu503.org 或拨打电话 1.844.503.SEIU (7348)，联系成员优势办公室。如需存取保障信息，请登录网站 araglegalcenter.com，并使用存取码 10540SEI 或拨打电话 1.800.247.4184。

Great Wolf Lodge 登录网站 greatwolf.com 或拨打 1.866.925.WOLF (9653)。使用企业代码：SEIU503 为您提供折扣。您须于核对时出示 SEIU Local 503 的证明，才有资格享有折扣。

奖学金计划登录网站 oregonstudentaid.gov，申请 SEIU Local 503 奖学金计划。

Motivano SmartSavings 登录网站 smartsavings.motivano.com。通过输入用户名：seiulocal503 和密码：Marketplace1，创建 您拥有的个人用户名和密码（用户名和密码须区分大小写和空格）。

Northwest Community Credit Union 在开立账户时，访问本地 Northwest Community Credit Union 分处或拨打 1.800.452.9515 参加 Perfect Partnerships 项目。参加时请提及您是 SEIU Local 503 的成员。

汽车和房屋保险如需获得汽车或房屋保险报价，拨打 1.855.734.8503。

Resident Lending Group 登录网站 residentlendinggroup.com 或拨打 1.503.589.1999，获取 SEIU 成员教育和资源链接。

SEIUMB，欲知专有折扣、财务服务和免费线上大学等教育福利的信息，请登录网站 SEIUMB.com。

寿险若有登记和保障相关问题，请发电子邮件至 membershipadvantages@seiu503.org 或拨打电话 1.844.503.SEIU (7348)，联系成员优势办公室。

Sunrise Dental 如需获取相关地点清单，请登录网站 sunrisedental.com。

退休策略和教育免费获得财务等级和财务审核，而无须支付成本或承担债务。拨打 1.503.684.4010 ， 分机 385，联系 Jason Hamilton。

SEIU Local 503
1.844.503.SEIU (7348)

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6401 SE Foster Road, Portland, OR 97206
525 Oregon Street, Portland OR 97232（新地点将于 2020 年公布）