WATER AND POWER
EMPLOYEES' RETIREMENT PLAN
111 North Hope Street, Room 357, Los Angeles, CA 90012
http://retirement.ladwp.com
(213) 367-1695

SUPPLEMENTAL FAMILY DEATH BENEFIT

The Plan provides a Family Death Benefit (FDB) allowance for each of your qualifying surviving children upon your death. The amount payable is $937 a month for each child, with a maximum amount not to exceed $2,187 a month.

In addition to the FDB allowance, the Plan provides an optional Supplemental Family Death Benefit (SFDB) allowance. If you die after completing 39 successive biweekly deductions to the program, your covered family members will each receive, in addition to the FDB allowance, $520 more a month up to a maximum amount of $1,066 more a month. The combined FDB and SFDB allowance is $1,457 a month for each child, with a maximum amount of $3,253 a month.

You must be an active member of the Retirement Plan to enroll. You become eligible for the benefit after you have made 39 successive biweekly deductions of $2.25 per pay period (about 18 months). You may discontinue coverage at any time. **Deductions for SFDB will continue until you notify the Retirement Plan Office that you want to stop deductions.**

SECTION A: *NEW APPLICATION*

I hereby authorize and direct the Department of Water and Power to deduct from my salary and pay into the Water and Power Employees' Death Benefit Fund all contributions for the Supplemental Family Death Benefit that said Fund requires of me under the terms of the Plan as it now exists or as it may hereafter be lawfully amended. I understand that these deductions will continue until I notify the Retirement Plan Office that I wish to terminate my coverage or my employment with the Department terminates.

Employee Name _____ Employee Number _____

Payroll Section _____ Birthdate of Youngest Child _____

Employee Signature _____ Date _____

SECTION B: *TO DISCONTINUE SUPPLEMENTAL FAMILY DEATH BENEFIT*

I do not have any children under the age of 18 years or any disabled children. I wish to discontinue my Supplemental Family Death Benefit Plan Coverage.

Employee Name _____ Employee Number _____

Employee Signature _____ Date _____

FOR OFFICE USE ONLY:

ENTERED INTO PENFAX BY:_____ DATE:_____

CHECKED BY:_____ DATE:_____