ASSOCIATED ADMINISTRATORS OF LOS ANGELES

MEMBER INFORMATION FORM

Employee Number _____

Name _____ ○ ○ ○ ○ ○ (Dr., Mr., Mrs., Ms., Miss)
(Last) (First) (MI.)

Home Address _____
(Number & Street) (City) (State) (Zip)

Home Phone ( ) _____ Date of Birth_____ Sex M ___ F ___
Area (Number)

E-Mail Address _____

Ethnicity (Check one)

○ American Indian ○ Asian ○ Black ○ Hispanic ○ White ○ Filipino ○ Pacific Islander ○ Other

Position Title _____ Location_____

Location Address _____ ESC _____

Location Phone ( ) _____ Ext.( ) Location Fax ( ) _____

Cell Phone ( ) _____

_____ I would be pleased to serve on an AALA/District Committee and/or Focus Group during the school year.

_____ I do not wish to serve on committees during this school year.

My professional interests are in the following field(s) of:

_____

_____

PRINT

Name _____

_____ Employee No.

Last First Middle Initial

Associated Administrators of Los Angeles

SALARY DEDUCTION AUTHORIZATION FORM

Location _____ Position or Classification _____

Must be filled in before employee signs:

*(Only new members fill in line **1**)*

1. Initial deduction for this organization- Amount $ 40.84

2. Increase my deduction for this organization by $ _____

3. Decrease my deduction for this organization by $ _____

May be filled in either before or after employee signs:

4. Present deduction $ _____

5. Increase or decrease $ _____

6. New total deduction $ _____

To: LOS ANGELES UNIFIED SCHOOL DISTRICT

You are hereby authorized to make a deduction from my salary twelve times a year, in the total amount indicated, for organization dues or organization dues and insurance premiums, and transmit the deduction to AALA. If an increase or decrease is requested and the new total deduction amount (line 6) is not filled out by me, it is understood that the increase or decrease will be added or subtracted by AALA to the deduction amount previously authorized by me to arrive at a new total deduction. It is expressly understood and agreed that dues increases up to a maximum of $25.00 per year and insurance increases not over 15% per year for the same basic coverage, may be made at the direction of AALA, without execution on my part of a new salary deduction authorization form only if AALA verifies in writing to the District that blanket notification has been made to its membership of such increase and only if AALA agrees to refund any deduction containing the increase if requested by me in writing to AALA within 30 days from the date the first increased deduction is made. I further understand and agree that the los Angeles Unified School District or its representative acting under this authorization shall not be liable in any manner for failure or delay on its (his) part in making the deduction or payment herein authorized.

This authorization shall remain in force until cancelled by written notice by AALA or myself.

_____

Employee Signature Approved by: (Organization)

Date _____ Effective Date _____

Mail or fax form. Mail: AALA, 1910 W. Sunset Blvd., Suite 850, Los Angeles, CA 90026
Fax: 213.484.0201

Designation of Beneficiary

Mutual of Omaha

Name of Employer: _____

Group Contract No(s): T66BA-33742

Name of Insured Member: _____

_____

Insured Member's Designation of Beneficiary

Subject to the terms of the above Group Contract(s), between **United of Omaha Life Insurance Company** and said policyholder, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me:

Primary Beneficiary Designation

Name of Beneficiary (First, MI, Last Name)	Related To Me As	Date of Birth (Mo./Day/Yr.)	Address of Beneficiary (Address, City, State, Zip)	Percentage (%)
			Percentage Total:	100%

Contingent Secondary Beneficiary Designation

Name of Beneficiary (First, MI, Last Name)	Related To Me As	Date of Birth (Mo./Day/Yr.)	Address of Beneficiary (Address, City, State, Zip)	Percentage (%)
			Percentage Total:	100%

*If more than one named, the beneficiaries shall share equally unless otherwise stated above.

Unless otherwise above expressly provided, if any beneficiary listed above designated predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries, if any, who survived me, but if no designated beneficiary survives me, the beneficiary shall be determined as prescribed in said Group Contract(s).

If this Designation of Beneficiary refers only to a Group Life Insurance contract and if I am insured also under a Group Death and Dismemberment insurance contract issued by United of Omaha Life Insurance Company, this designation shall apply to both contracts unless I made a separate designation on or after the date of this designation.

This Designation of Beneficiary is subject to change as provided in said Group Contract(s).

WITNESS _____ _____

Signature of Insured Member

Date of Insured Member's Signature _____

Return original to employer or policy administrator.

Acknowledgment

The above beneficiary designation has been recorded by policyholder on behalf of insurer. A copy of this designation is being returned for your records.

Date Recorded _____ _____

Signed by Benefits Manager for the Policyholder

Instructions

1. If a mistake is made, no erasures or corrections should be attempted, but a new form should be used.
2. If a married woman is to be named, her full given name should be shown — for example: Mary J. Smith, not Mrs. John H. Smith. Likewise, if the card is to be signed by a married woman, she should sign her given name.
3. When two or more beneficiaries are to be named and they are not to share equally, the percentage each beneficiary is to receive should be shown; dollars and cents should not be specified.
4. If there are any questions, you should consult the person handling the group insurance at your policyholder's office.