WATER AND POWER
EMPLOYEES' RETIREMENT PLAN

111 North Hope Street, Room 357, Los Angeles, CA 90012
http://retirement.ladwp.com
(213) 367-1715

SUPPLEMENTAL FAMILY DEATH BENEFIT - Retired

The Plan provides a Family Death Benefit (FDB) allowance for each of your qualifying surviving children upon your death. The amount payable is $416 a month for each child, with a maximum amount not to exceed $1,170 a month.

In addition to the FDB allowance, the Plan provides an optional Supplemental Family Death Benefit (SFDB) allowance. If you die, 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 $936 a month for each child, with a maximum amount of $2,236 a month.

If you are currently enrolled in SFDB and have paid 39 biweekly deductions into the program prior to your retirement, you may elect to continue SFDB benefit upon retirement. Deduction is $4.90 per month and it will be deducted from your monthly allowance. 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.**

NOTE: If you are retired and terminate SFDB, you may NOT re-enroll into the SFDB program.

SECTION A: *TO CONTINUE SFDB ENROLLMENT*

(must have already qualified for SFDB prior to retirement)

I hereby authorize and direct the Water and Power Employees' Retirement Plan to deduct from my alllowance 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.

Employee Name _____ Employee Number _____

Retirement Date _____ 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 _____

SFDB 02/04/16

FOR OFFICE USE ONLY:

ENTERED INTO PENFAX BY:_____ DATE:_____

CHECKED BY:_____ DATE:_____