ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Accidental death and dismemberment benefits are provided for all participants in the Wage Supplement Plan.

The maximum benefit provided is $2,500.00 per accidental injury. Actual benefit amounts are as follows:

For Loss of	***The Benefit Will Be***
Life	$ 2,500.00
Both hands or both feet	$ 2,500.00
The sight of both eyes	$ 2,500.00
One hand and one foot	$ 2,500.00
One hand or one foot and the sight of one eye	$ 2,500.00
One hand or one foot	$ 1,250.00
The sight of one eye	$ 1,250.00

The County will pay the applicable benefit amount upon receipt of due proof that:

1. You were accidentally injured while insured under the Plan; and
2. The loss occurred as a direct result of the injury and within 90 days after the accidental injury.

DISABILITY, DEATH OR DISMEMBERMENT GENERAL EXCEPTIONS AND LIMITATIONS

This plan does NOT cover disability, death or dismemberment resulting from:

1. Accidental injury arising out of or in the course of any occupation or employment for remuneration or profit, or any accidental injury or any sickness for which you are entitled to benefits under any Workers' Compensation law, Employers' Liability law, or similar law.
2. Disease, bodily or mental infirmity or infection.
3. Suicide, attempted suicide or intentionally self-inflicted injury whether sane or insane.
4. Being in or on, descending from or following with or from any aircraft which is in flight or motion unless insured as a fare-paying passenger on a commercial airline flying a regularly scheduled route.
5. Use of any drug, narcotic or hallucinogenic agent unless prescribed by a physician.
6. Injury or sickness resulting from war or any act of war; whether declared or undeclared, or from participation in a riot or from commission of a felony.

TERMINATION OF COVERAGE

Your Wage Supplement Plan coverage will automatically terminate on the earliest of :

1. the day the Plan terminates;
2. the day you cease to be eligible;
3. the day you enter the armed forces or accept a government agency position outside the United States;
4. the end of the pay period in which you discontinue payment of premiums.

TO FILE A CLAIM

Obtain a WSP Claim Statement from your Department's Human Resources Benefits Representative. Follow the instructions on the Statement. To expedite your claim, make a copy of Part I, complete it and send it directly to Human Resources Benefits Unit. Give Part II to your Department to complete and send to Benefits. Give Part III to you physician to complete and send directly to Benefits. Your claim will be processed as soon as all three (3) parts have been received and the information has been verified.

IF YOU HAVE QUESTIONS

County of Ventura

Human Resources Department, Benefits Unit

Hall of Administration, 4th Floor

800 South Victoria Avenue, # 1970

Ventura, CA 93009

(805) 654-2780

IMPORTANT

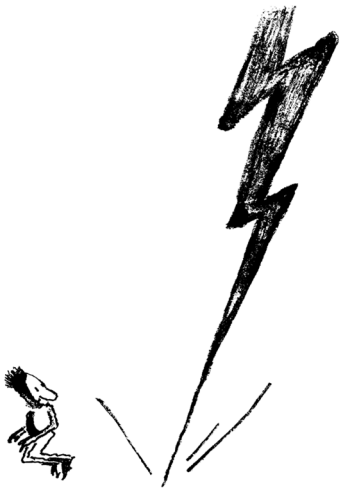
This brochure is a brief summary of the plan. Statements in this brochure are subject to the provisions of the County of Ventura's Wage Supplement Plan for Short-Term Disability and cannot modify or affect the Plan in any way, nor shall you accrue any right because of a statement or omission from this brochure.

The Plan Document is available for review in the County of Ventura's Human Resources Department.

COUNTY OF VENTURA

Wage Supplement Plan

For Short-Term Disability Benefits



An Optional Program

County Executive Office

Human Resources Department

Benefits Division

COUNTY OF VENTURA

WAGE SUPPLEMENT PLAN ENROLLMENT FORM

EMPLOYEE I.D. NUMBER	**DEPARTMENT NAME**	☐ Male ☐ Female	☐ Single ☐ Married	**SCHEDULED HOURS PER WEEK**
EMPLOYEE NAME (Last, First, Middle Initial)			**ADDRESS** (Number and Street or P.O. Box, City, State, Zip Code)	
☐ **I CHOOSE LOW OPTION** – Maximum Benefit Period 13 weeks			**DATE OF BIRTH**	$ Salary Biweekly
☐ **I CHOOSE HIGH OPTION** – Maximum Benefit Period 26 weeks			**DATE EMPLOYED**	$ Salary Per Hour
Primary **FULL NAME OF BENEFICIARY** (First, Middle, Last)	**SSN**	**RELATIONSHIP**	**ADDRESS** (Number and Street or P.O. Box, City , State, Zip Code)	
Contingent				

SIGNATURE OF SPOUSE AND TODAY'S DATE (If you are married and you designate a primary beneficiary other than your spouse, your spouse must give consent by signing this form.)

I designate the beneficiary shown above to receive all sums which may become due on account of my death under the Accidental Death and Dismemberment Benefit provided by this Plan. I have a regular work schedule of 20 or more hours per week (40 hours or more each pay period). I hereby request coverage under the Wage Supplement Plan and authorize the County to deduct from my earnings any required contributions. I certify that any information shown on this form is correct.

SIGNATURE OF EMPLOYEE: **TODAY'S DATE:**

Human Resources Department Name and Date Processed: **Pay Period Deduction and Coverage Effective:**

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Wage Supplement Plan

For Short-Term Disability Benefits

An Optional Program

This plan brochure describes your plan benefits and the procedure for filing a claim. Keep it with your important papers for future reference.

WHY DISABILITY INCOME INSURANCE?

All the essentials of life depend on your most valuable possession – your earning ability. What would happen if you were disabled and stopped receiving a paycheck? When you're disabled, most of your bills and expenses continue and you may even need household help to care for you, your family and your home. This plan can help you minimize your financial loss while you recover from a serious non-work-related illness or injury.

ELIGIBILITY AND ENROLLMENT

All regular employees are eligible to participate as long as you are regularly scheduled to work 20 hours or more per week (40 hours per pay period). Evidence of insurability is not required. New and current employees can enroll as soon as they meet the eligibility requirements.

To enroll, you must detach and complete the Enrollment Form and return it to your Department's Human Resources Benefits Representative in time to be forwarded to the Human Resources Benefits Unit during the first **90 days** you are eligible, or you will not be a participant in the plan. There are no regular open enrollment periods. Coverage begins the second day of the pay period in which your Enrollment Form is processed. You can cancel your enrollment at any time by submitting a Payroll Authorization/Cancellation Deduction Card. Once you drop your coverage, you cannot reenroll.

DEFINITION OF TOTAL DISABILITY

You are considered to be totally disabled if you are unable to perform each and every duty of your regular occupation at your customary place of employment each and every day and you are under the regular care of a physician.

PLAN PROVISIONS

If you become totally disabled while enrolled in this plan and submit a completed Claim Statement as described elsewhere in this brochure, benefits will begin on the first day of your injury or hospitalization, or on the 8th day of an illness not requiring hospitalization. Benefits are paid bi-weekly.

The dollar amount of weekly benefits and the maximum benefit period are determined by the premium and level of coverage you select, as follows:

Premium Per Pay Period	*Weekly $ Benefit*	*Maximum Benefit Period*	*Maximum Benefit Per Disability*
$3.13	$45.00	13 weeks	$5 85.00
$7.00	$80.00	26 weeks	$2,080.00

Premium rates are subject to change. The higher level of coverage is available only for employees whose regular bi-weekly earnings exceed $369.00.

WSP Benefits are not reduced by any other insurance you may have, and do not affect the amount of State Disability Insurance (SDI) Benefits to which you may be entitled. However, if you also have other group disability insurance, you may wish to check with that plan to see whether those benefits would be reduced by the amount of your WSP Benefit. For example, the County's Long Term Disability (LTD) Benefits would be reduced by the amount of the WSP Benefit.

DISABILITY INSURANCE EXCEPTIONS

Successive periods of disability will be considered as one continuous period of total disability if they result from, or are contributed to by, the same or related causes. However, if you performed your regular occupation at your customary place of employment for at least 20 hours a week for a period of at least two weeks between periods of total disability, the periods are considered separate periods of disability.

Members age 70 or over will be paid the Weekly Benefit, for up to the maximum benefit period specified, for any one disability during any period of twelve (12) consecutive months.