STL Retired Term Life Application Form

1. Fill out application.
2. Sign and Date the form.
3. Submit your application to the Trust.

MetLife

CCPOA Benefit Trust Fund | 2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235 | (916) 779-6300 | **www.ccpoabtf.org**

ALREADY RETIRED – USE THIS FORM

Request for Group Insurance from:	**Retired Term Life**	**Retired**

Underwritten by: Metropolitan Life Insurance Company I 200 Park Avenue I New York, NY 10166
Offered through CCPOA Benefit Trust Fund (916) 779-6300

Mail completed form to: CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

MEMBER INFORMATION

Full Name (First):	(Middle Initial)	(Last)	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female
Address:			City:	State:	ZIP:
Phone:			Smoker:: ☐ Yes ☐ No	Employee Hire Date:	Occupation or Position:
E-mail:					

BENEFICIARY INFORMATION Note: If you need to ADD ADDITIONAL BENEFICIARIES please attach another sheet of paper

Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			

The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

For Retired CCPOA Member

I hereby apply for a **benefit amount** of:

$_____

($25,000 minimum up to $1,000,000 maximum in $25,000 increments. See rate chart.)

☐ New Coverage ☐ Change in coverage

For Retired CCPOA Member's Spouse

I hereby apply for a **benefit amount** of:

$_____

($12,500 minimum up to $250,000 maximum in increments of $12,500. The spouse benefit amount must be no greater than 50% of the member's coverage.)

☐ Coverage for dependent child(ren). $10,000 benefit

Is spouse an Active or Retired CCPOA Member? Check box: ☐ **Yes** or ☐ **No** Note: If you are covered as a member, you cannot be covered as a dependent of another member.

Continued on back

If Spouse/Dependent Coverage is desired, complete the following:		
Full Name of Spouse/Dependent Children	**Relationship**	**Birth Date**

I hereby enroll in the Retired Term Life Program, underwritten by Metropolitan Life Insurance Company and offered through the CCPOA Benefit Trust Fund.
I have read and understand the conditions and exclusions of the program. I understand that my coverage will become effective upon the first day of the month following the administrator's receipt of this enrollment form and my first premium payment.

By signing and dating this application, I request the insurance indicated, understand the effective date criteria, and attest to having read the Fraud Notice indicated above, and that to the best of my knowledge and belief, the answers to the questions are true and complete. I understand the principal sum automatically reduces based on the schedule in my Certificate of Insurance and that the premium is payroll deducted.

Fraud Notice – For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I hereby authorize the State Controller to deduct from my salaries and wages the amount specified now or in the future for membership dues and any benefit program for which I have applied, which is sponsored by the California Correctional Peace Officers Association (CCPOA). The authorization will remain in effect until canceled by me or by CCPOA. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization.

Signature of Applicant:	**Date of Application:**
X	

Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

RETIRED