



CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

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CCPOA Active Members

GROUP SUPPLEMENTAL TERM LIFE INSURANCE



Please complete and return this form to the Benefit Trust Fund

Residents of New York please call the Trust at 1-800-468-6486 for a NY specific application.

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010

Please Print Use Dark Ink Do Not Erase Initial All Changes.				Office Use:			
Policyholder and Participating Organizations: CCPOA Benefit Trust Fund		Policy No. G29307	Height: Ft _____ In _____ Weight: _____ lb				
CCPOA Members Name (first, Middle Initial, Last)		Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female				
Street:		Phone No.:	Last 4 of SSN:				
City:	Email:	State:	Zip:				
Proposed Insured's Occupation and Facility:							
Beneficiary – Print full name & relationship to you							
Name (Primary):		Relationship:					
Beneficiary Address:				Beneficiary SSN:			
Name (Contingent):		Relationship:					
Beneficiary Address:				Beneficiary SSN:			
The Proposed Insured will be the beneficiary for any Dependent Coverage desired.							
For CCPOA Member I hereby apply for a benefit amount of: \$ _____ <i>(\$25,000 minimum up to \$500,000 maximum in \$25,000 increments. See rate chart.)</i> <input type="checkbox"/> New Coverage <input type="checkbox"/> Change in coverage IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT TOTAL AMOUNT DESIRED			For CCPOA Member's Spouse I hereby apply for a benefit amount of: \$ _____ <i>(\$12,500 minimum up to \$50,000 maximum in increments of \$12,500. The spouse benefit amount must be no greater than 50 percent of the member's coverage.)</i> Is spouse an Active or Retired CCPOA Member? Check box: <input type="checkbox"/> Yes or <input type="checkbox"/> No <input type="checkbox"/> Coverage for dependent child(ren). \$750/\$7,500 benefit IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT TOTAL AMOUNT DESIRED				
For Office Use Only _____			For Office Use Only _____				
If Spouse/Dependent Coverage is desired, complete the following:							
Full Name of Spouse/Dependent Children	Relationship	Birth Date	Height	Weight			
Member Statement of Health:							
To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:				MEMBER		SPOUSE	
A	Are you taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?			YES	NO	YES	NO
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	During the past five years have you ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus, or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?						
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C	During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs?						
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continued on next page

Details (please fill out if answered "YES" to A, B, or C)

Depending on the amount of insurance you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history.

What time and telephone number would be best to contact you? _____

Please check "Yes" or "No"

By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance?

Member: YES NO

Spouse: YES NO

Do you have other life insurance in force?

If "Yes" total amount in all companies:

Member: \$ _____ Spouse: \$ _____

Do you have other insurance applications pending?

If "Yes" indicate amount and company.

Member: \$ _____ Spouse: \$ _____

Company: _____ Company: _____

FRAUD NOTICE – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

AUTHORIZATION & SIGNATURE: I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, I member/spouse request the insurance indicated; and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE enclosed, including making a brief report of [my/our] protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE enclosed and Fraud Notice indicated above, including how [my/our] information is exchanged with MIB, and that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete.

Member Signature	Date
Spouse Signature (if enrolling)	Date

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 cancelled 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.