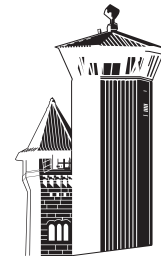


Disability Application Form

1. Print-out this form.
2. Fill out application.
3. Sign and Date the form.
4. Mail your application to:

CCPOA Benefit Trust Fund

2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235
www.ccpoabtf.org



Fold down and seal to return mail

Application CCPOA Disability Benefit Plan			Active																																										
Full Name (print):		Birthdate:	SSN (Last 4):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female																																									
Address:		City:	State:	ZIP:																																									
Phone:	Graduation Date (New Officer Only):		IN THE PAST 5 YEARS has there existed, or have you been treated for or told by a physician or practitioner that you have conditions implicating any of the following:																																										
E-mail:			<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>A. The brain, nervous system, epilepsy, Parkinson's disease, stroke, mental or nervous disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>F. The endocrine system including diabetes, thyroid or adrenal disorders?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>B. The respiratory system including tuberculosis, emphysema or COPD?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>G. Cancer, tumor, Hodgkin's disease, leukemia, muscle disorders including Muscular Dystrophy or Multiple Sclerosis?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>C. The heart, heart attack, heart murmur, blood, anemia, high blood pressure, rheumatic fever or vascular disease?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>H. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV or any other immune deficiency disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>D. The gastrointestinal tracts, stomach, gall bladder, liver, hepatitis or pancreas disorders?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>I. Bone Disease or bone injuries including fractures?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>E. The genito-urinary system, kidneys, reproductive organs including prostatitis or uterine fibroids?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>J. Any injury, disease, condition or abnormality not mentioned above?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="3">K. Are you actively working within the duties of your occupation?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> </tbody> </table>		YES	NO		YES	NO	A. The brain, nervous system, epilepsy, Parkinson's disease, stroke, mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	F. The endocrine system including diabetes, thyroid or adrenal disorders?	<input type="checkbox"/>	<input type="checkbox"/>	B. The respiratory system including tuberculosis, emphysema or COPD?	<input type="checkbox"/>	<input type="checkbox"/>	G. Cancer, tumor, Hodgkin's disease, leukemia, muscle disorders including Muscular Dystrophy or Multiple Sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	C. The heart, heart attack, heart murmur, blood, anemia, high blood pressure, rheumatic fever or vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>	H. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV or any other immune deficiency disorder?	<input type="checkbox"/>	<input type="checkbox"/>	D. The gastrointestinal tracts, stomach, gall bladder, liver, hepatitis or pancreas disorders?	<input type="checkbox"/>	<input type="checkbox"/>	I. Bone Disease or bone injuries including fractures?	<input type="checkbox"/>	<input type="checkbox"/>	E. The genito-urinary system, kidneys, reproductive organs including prostatitis or uterine fibroids?	<input type="checkbox"/>	<input type="checkbox"/>	J. Any injury, disease, condition or abnormality not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	K. Are you actively working within the duties of your occupation?			<input type="checkbox"/>	<input type="checkbox"/>	
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Plan Selection at current monthly rate (Check One) <i>All Rates effective 07/01/2019</i> <input type="checkbox"/> GOLD SHIELD \$55.00/mo <input type="checkbox"/> SILVER SHIELD \$45.00/mo <input type="checkbox"/> New Officer Special Offer \$27.50/mo 1st year Gold Shield		Please explain all of the "YES" answers checked, except "K" (including dates) If necessary, use additional paper. The falsity or lack of completeness of any statement made on this application shall be sufficient reason for the denial, suspension or termination of benefits under this program.		ACTIVE																																									
Date of Graduation: (Must be within 90 days to qualify)																																													
<small>*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). This authorization will remain in effect until canceled by me or by CCPOA Benefit Trust Fund. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization.*</small>				Date of Application:																																									
Signature of Applicant: X																																													

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We've Got You Covered.

1-800-In-Unit-6

1-800-468-6486