

ADD

AD&D: Retired Application Form



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



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

Request for Group Insurance from:	Group Accidental Death And Dismemberment Insurance			Retired	
Underwritten by: Metropolitan Life Insurance Company 200 Park Avenue 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:		Relationship:		Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: <i>Applicant will be Spouse's and Dependent's beneficiary</i>					
DEPENDENT INFORMATION Note: If you need to ADD ADDITIONAL DEPENDENTS, please attach another sheet of paper					
Dependent:	Relationship:		Date of Birth:	Sex: ☐ Male ☐ Female	
Dependent:	Relationship:		Date of Birth:	Sex: ☐ Male ☐ Female	
Dependent:	Relationship:		Date of Birth:	Sex: ☐ Male ☐ Female	
Plan Selection (Check One) ☐ Member Only ☐ Family Plan*			Amount of Insurance - Spouse and Children covered only if Family Plan is checked		
AMOUNT REQUESTED: \$ _____ <i>See Back for Rate Chart</i>			Member 100% of Principal Sum	Spouse 60% of Principal Sum (if NO children) 50% of Principal Sum (if children)w	Each Child 15% of Principal Sum (if spouse) 20% of Principal Sum (if NO spouse)
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.					
I hereby enroll in the Accidental Death and Dismemberment 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.					
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.					
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.					
Signature of Applicant: X				Date of Application:	

AD&D: Retired Rate Information

COVERAGE AMOUNT:

Amount of Insurance - Spouse and Children covered only if Family Plan is checked		
Member 100% of Principal Sum	Spouse 60% of Principal Sum (if NO children) 50% of Principal Sum (if children)	Each Child 15% of Principal Sum (if spouse) 20% of Principal Sum (if NO spouse)
Rates are based on per \$1,000 of coverage. Rates are in \$25K increments, up to \$1M Max		Member Only: \$0.060/\$1,000 Family: \$0.090/\$1,000

SAMPLE RATE CHART: Monthly Premium

	\$25,000	\$50,000	\$100,000	\$500,000	\$1,000,000
Member Only	\$1.50	\$3.00	\$6.00	\$30.00	\$60.00
Family	\$2.25	\$4.50	\$9.00	\$45.00	\$90.00

You may purchase coverage in any amount up to \$1,000,000 in increments of \$25,000.
 Your premium is deducted monthly.

AD&D MONTHLY PREMIUM		
	Member Only	Family
25,000	\$1.50	2.25
50,000	\$3.00	4.5
75,000	\$4.50	6.75
100,000	\$6.00	9.00
125,000	\$7.50	11.25
150,000	\$9.00	13.50
175,000	\$10.50	15.75
200,000	\$12.00	18.00
225,000	\$13.50	20.25
250,000	\$15.00	22.50
275,000	\$16.50	24.75
300,000	\$18.00	27.00
325,000	\$19.50	29.25
350,000	\$21.00	31.50
375,000	\$22.50	33.75
400,000	\$24.00	36.00
425,000	\$25.50	38.25
450,000	\$27.00	40.50
475,000	\$28.50	42.75
500,000	\$30.00	45.00

AD&D MONTHLY PREMIUM		
	Member Only	Family
525,000	\$31.50	47.25
550,000	\$33.00	49.50
575,000	\$34.50	51.75
600,000	\$36.00	54.00
625,000	\$37.50	56.25
650,000	\$39.00	58.50
675,000	\$40.50	60.75
700,000	\$42.00	63.00
725,000	\$43.50	65.25
750,000	\$45.00	67.50
775,000	\$46.50	69.75
800,000	\$48.00	72.00
825,000	\$49.50	74.25
850,000	\$51.00	76.50
875,000	\$52.50	78.75
900,000	\$54.00	81.00
925,000	\$55.50	83.25
950,000	\$57.00	85.50
975,000	\$58.50	87.75
1,000,000	\$60.00	90.00



1. Fill out application.
 2. Sign and Date the form.
 3. Submit your application to the Trust.
- Or fax this form to: 916-779-6355 | Attn: Enrollment



MetLife

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

Application MetLife Retired Legal Plan

Retired

Underwritten by: Metropolitan Life Insurance Company | 200 Park Avenue | 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:					

■ Program Selection at current monthly rate (Check One)

☐ **MetLife Retired Legal Plan \$13.99/mo**
Excludes Legal Defense Fund Benefits

Yes, I elect to enroll in MetLife Legal Plans and authorize CalPERS to deduct from my retirement allowance the amount required to cover my share of the cost of enrollment, as it is now of \$13.99 per pay period, or as it may be in the future. I understand that this authorization will remain in effect until I cancel it, as long as I remain eligible. I certify I am a retired CCPOA member and that ending my membership will stop all related deductions.

I hereby enroll in the MetLife Retired Legal 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.

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.

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.

Signature of Applicant:

Date of Application:

X



Piggyback Dental Retired Application Form



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



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

Application CCPOA Piggyback Dental Program			Retired
CCPOA Benefit Trust Fund (916) 779-6300			
Full Name (Print):	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female
Address:			
City:	State:	ZIP:	Phone:
E-mail:			
List below names and birth dates of spouse and all dependent children under 26 years of age. (Birth dates are required)			
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship
☒ Plan Selection at current monthly rate (Check One) ☐ Retired Member Only \$18.00 ☐ Retired Member and one or more dependents \$34.00		I hereby authorize the CalPERS 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. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization.	
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.			
Signature of Applicant: X			Date of Application:

Note: If you need to ADD ADDITIONAL DEPENDENTS, please attach another sheet of paper



Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

RETIRED

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 200 Park Avenue 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: <i>Applicant will be Spouse's and Dependent's beneficiary</i>					
Beneficiary:		Relationship:		Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: <i>Applicant will be Spouse's and Dependent's beneficiary</i>					
Beneficiary:		Relationship:		Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: <i>Applicant will be Spouse's and Dependent's beneficiary</i>					
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:

Date of Spouse: (if enrolling)

Date of Application:

Retired Term Life Roll-Over 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

RETIRING AND HAVE TERM LIFE – USE THIS FORM

Request for Group Insurance from:	Retired Term Life Roll-Over				Retired
Underwritten by: Metropolitan Life Insurance Company 200 Park Avenue 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:					
I have joined the CCPOA Retired Chapter and am seeking to rollover my Supplemental Term Life into retirement ☐ _____ (initial here)					
BENEFICIARY INFORMATION Note: If you need to ADD ADDITIONAL BENEFICIARIES please attach another sheet of paper					
Beneficiary:		Relationship:		Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: <i>Applicant will be Spouse's and Dependent's beneficiary</i>					
Beneficiary:		Relationship:		Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: <i>Applicant will be Spouse's and Dependent's beneficiary</i>					
Beneficiary:		Relationship:		Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: <i>Applicant will be Spouse's and Dependent's beneficiary</i>					
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.)			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

WHEN IS COVERAGE EFFECTIVE?
The participant's effective date of coverage shall be determined upon completion of your term life insurance conversion request, retirement date, and approval. The coverage will commence on the first (1st) day of the next calendar month immediately following the date on which a payroll deduction is made for your Retired Life insurance premium, provided you are a CCPOA retired chapter member on that date. You do not receive temporary or conditional insurance just because you submit a request for rollover.

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.	
Member Signature	Date
Spouse Signature (if enrolling)	Date

CURRENT RETIRED MEMBER INDIVIDUAL MONTHLY PREMIUMS Effective January 1, 2027

Reduces by 50% at age 60, and lesser of 50% or \$50K at 70

	0-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59
\$25,000	\$2.00	\$2.00	\$2.25	\$2.75	\$3.50	\$5.50	\$8.50	\$16.25
\$50,000	\$4.00	\$4.00	\$4.50	\$5.50	\$7.00	\$11.00	\$17.00	\$32.50
\$75,000	\$6.00	\$6.00	\$6.75	\$8.25	\$10.50	\$16.50	\$25.50	\$48.75
\$100,000	\$8.00	\$8.00	\$9.00	\$11.00	\$14.00	\$22.00	\$34.00	\$65.00
\$125,000	\$10.00	\$10.00	\$11.25	\$13.75	\$17.50	\$27.50	\$42.50	\$81.25
\$150,000	\$12.00	\$12.00	\$13.50	\$16.50	\$21.00	\$33.00	\$51.00	\$97.50
\$175,000	\$14.00	\$14.00	\$15.75	\$19.25	\$24.50	\$38.50	\$59.50	\$113.75
\$200,000	\$16.00	\$16.00	\$18.00	\$22.00	\$28.00	\$44.00	\$68.00	\$130.00
\$225,000	\$18.00	\$18.00	\$20.25	\$24.75	\$31.50	\$49.50	\$76.50	\$146.25
\$250,000	\$20.00	\$20.00	\$22.50	\$27.50	\$35.00	\$55.00	\$85.00	\$162.50
\$275,000	\$22.00	\$22.00	\$24.75	\$30.25	\$38.50	\$60.50	\$93.50	\$178.75
\$300,000	\$24.00	\$24.00	\$27.00	\$33.00	\$42.00	\$66.00	\$102.00	\$195.00
\$325,000	\$26.00	\$26.00	\$29.25	\$35.75	\$45.50	\$71.50	\$110.50	\$211.25
\$350,000	\$28.00	\$28.00	\$31.50	\$38.50	\$49.00	\$77.00	\$119.00	\$227.50
\$375,000	\$30.00	\$30.00	\$33.75	\$41.25	\$52.50	\$82.50	\$127.50	\$243.75
\$400,000	\$32.00	\$32.00	\$36.00	\$44.00	\$56.00	\$88.00	\$136.00	\$260.00
\$425,000	\$34.00	\$34.00	\$38.25	\$46.75	\$59.50	\$93.50	\$144.50	\$276.25
\$450,000	\$36.00	\$36.00	\$40.50	\$49.50	\$63.00	\$99.00	\$153.00	\$292.50
\$475,000	\$38.00	\$38.00	\$42.75	\$52.25	\$66.50	\$104.50	\$161.50	\$308.75
\$500,000	\$40.00	\$40.00	\$45.00	\$55.00	\$70.00	\$110.00	\$170.00	\$325.00
\$525,000	\$42.00	\$42.00	\$47.25	\$57.75	\$73.50	\$115.50	\$178.50	\$341.25
\$550,000	\$44.00	\$44.00	\$49.50	\$60.50	\$77.00	\$121.00	\$187.00	\$357.50
\$575,000	\$46.00	\$46.00	\$51.75	\$63.25	\$80.50	\$126.50	\$195.50	\$373.75
\$600,000	\$48.00	\$48.00	\$54.00	\$66.00	\$84.00	\$132.00	\$204.00	\$390.00
\$625,000	\$50.00	\$50.00	\$56.25	\$68.75	\$87.50	\$137.50	\$212.50	\$406.25
\$650,000	\$52.00	\$52.00	\$58.50	\$71.50	\$91.00	\$143.00	\$221.00	\$422.50
\$675,000	\$54.00	\$54.00	\$60.75	\$74.25	\$94.50	\$148.50	\$229.50	\$438.75
\$700,000	\$56.00	\$56.00	\$63.00	\$77.00	\$98.00	\$154.00	\$238.00	\$455.00
\$725,000	\$58.00	\$58.00	\$65.25	\$79.75	\$101.50	\$159.50	\$246.50	\$471.25
\$750,000	\$60.00	\$60.00	\$67.50	\$82.50	\$105.00	\$165.00	\$255.00	\$487.50
\$775,000	\$62.00	\$62.00	\$69.75	\$85.25	\$108.50	\$170.50	\$263.50	\$503.75
\$800,000	\$64.00	\$64.00	\$72.00	\$88.00	\$112.00	\$176.00	\$272.00	\$520.00
\$825,000	\$66.00	\$66.00	\$74.25	\$90.75	\$115.50	\$181.50	\$280.50	\$536.25
\$850,000	\$68.00	\$68.00	\$76.50	\$93.50	\$119.00	\$187.00	\$289.00	\$552.50
\$875,000	\$70.00	\$70.00	\$78.75	\$96.25	\$122.50	\$192.50	\$297.50	\$568.75
\$900,000	\$72.00	\$72.00	\$81.00	\$99.00	\$126.00	\$198.00	\$306.00	\$585.00
\$925,000	\$74.00	\$74.00	\$83.25	\$101.75	\$129.50	\$203.50	\$314.50	\$601.25
\$950,000	\$76.00	\$76.00	\$85.50	\$104.50	\$133.00	\$209.00	\$323.00	\$617.50
\$975,000	\$78.00	\$78.00	\$87.75	\$107.25	\$136.50	\$214.50	\$331.50	\$633.75
\$1,000,000	\$80.00	\$80.00	\$90.00	\$110.00	\$140.00	\$220.00	\$340.00	\$650.00

CURRENT RETIRED MEMBER INDIVIDUAL MONTHLY PREMIUMS Effective January 1, 2027

Reduces by 50% at age 60, and lesser of 50% or \$50K at 70

	60-64	65-69	70-74	75-79	80-84	85-89	90+
\$25,000	\$25.00	\$39.75	\$60.50	\$112.25	\$180.00	\$295.00	\$478.00
\$50,000	\$50.00	\$79.50	\$121.00	\$224.50	\$360.00	\$590.00	\$956.00
\$75,000	\$75.00	\$119.25					
\$100,000	\$100.00	\$159.00					
\$125,000	\$125.00	\$198.75					
\$150,000	\$150.00	\$238.50					
\$175,000	\$175.00	\$278.25					
\$200,000	\$200.00	\$318.00					
\$225,000	\$225.00	\$357.75					
\$250,000	\$250.00	\$397.50					
\$275,000	\$275.00	\$437.25					
\$300,000	\$300.00	\$477.00					
\$325,000	\$325.00	\$516.75					
\$350,000	\$350.00	\$556.50					
\$375,000	\$375.00	\$596.25					
\$400,000	\$400.00	\$636.00					
\$425,000	\$425.00	\$675.75					
\$450,000	\$450.00	\$715.50					
\$475,000	\$475.00	\$755.25					
\$500,000	\$500.00	\$795.00					

CURRENT RETIRED SPOUSE INDIVIDUAL MONTHLY PREMIUMS Effective January 1, 2027

Spouse benefit reduces by 50% at age 60, and lesser of 50% or \$25K at 70

	0-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59
\$12,500	\$0.88	\$0.88	\$1.00	\$1.25	\$1.75	\$2.75	\$3.75	\$4.75
\$25,000	\$1.75	\$1.75	\$2.00	\$2.50	\$3.50	\$5.50	\$7.50	\$9.50
\$37,500	\$2.63	\$2.63	\$3.00	\$3.75	\$5.25	\$8.25	\$11.25	\$14.25
\$50,000	\$3.50	\$3.50	\$4.00	\$5.00	\$7.00	\$11.00	\$15.00	\$19.00
\$62,500	\$4.38	\$4.38	\$5.00	\$6.25	\$8.75	\$13.75	\$18.75	\$23.75
\$75,000	\$5.25	\$5.25	\$6.00	\$7.50	\$10.50	\$16.50	\$22.50	\$28.50
\$87,500	\$6.13	\$6.13	\$7.00	\$8.75	\$12.25	\$19.25	\$26.25	\$33.25
\$100,000	\$7.00	\$7.00	\$8.00	\$10.00	\$14.00	\$22.00	\$30.00	\$38.00
\$112,500	\$7.88	\$7.88	\$9.00	\$11.25	\$15.75	\$24.75	\$33.75	\$42.75
\$125,000	\$8.75	\$8.75	\$10.00	\$12.50	\$17.50	\$27.50	\$37.50	\$47.50
\$137,500	\$9.63	\$9.63	\$11.00	\$13.75	\$19.25	\$30.25	\$41.25	\$52.25
\$150,000	\$10.50	\$10.50	\$12.00	\$15.00	\$21.00	\$33.00	\$45.00	\$57.00
\$162,500	\$11.38	\$11.38	\$13.00	\$16.25	\$22.75	\$35.75	\$48.75	\$61.75
\$175,000	\$12.25	\$12.25	\$14.00	\$17.50	\$24.50	\$38.50	\$52.50	\$66.50
\$187,500	\$13.13	\$13.13	\$15.00	\$18.75	\$26.25	\$41.25	\$56.25	\$71.25
\$200,000	\$14.00	\$14.00	\$16.00	\$20.00	\$28.00	\$44.00	\$60.00	\$76.00
\$212,500	\$14.88	\$14.88	\$17.00	\$21.25	\$29.75	\$46.75	\$63.75	\$80.75
\$225,000	\$15.75	\$15.75	\$18.00	\$22.50	\$31.50	\$49.50	\$67.50	\$85.50
\$237,500	\$16.62	\$16.62	\$19.00	\$23.75	\$33.25	\$52.25	\$71.25	\$90.25
\$250,000	\$17.50	\$17.50	\$20.00	\$25.00	\$35.00	\$55.00	\$75.00	\$95.00

CURRENT RETIRED SPOUSE INDIVIDUAL MONTHLY PREMIUMS Effective January 1, 2027

Spouse benefit reduces by 50% at age 60, and lesser of 50% or \$25K at 70

	60-64	65-69	70-74	75-79	80-84	85-90	90+
\$12,500	\$11.88	\$18.75	\$30.88	\$57.00	\$92.62	\$149.88	\$240.50
\$25,000	\$23.75	\$37.50	\$61.75	\$114.00	\$185.25	\$299.75	\$481.00
\$37,500	\$35.62	\$56.25					
\$50,000	\$47.50	\$75.00					
\$62,500	\$59.38	\$93.75					
\$75,000	\$71.25	\$112.50					
\$87,500	\$83.12	\$131.25					
\$100,000	\$95.00	\$150.00					
\$112,500	\$106.88	\$168.75					
\$125,000	\$118.75	\$187.50					



VSP Retired Application Form



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



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

Application CCPOA Vision Program				Retired										
CCPOA Benefit Trust Fund (916) 779-6300														
Full Name (Print):		Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female										
Address:														
City:	State:	ZIP	Phone:											
E-mail:														
List below names and birth dates of spouse and all dependent children under 26 years of age. (Birth dates are required)														
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship											
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship											
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship											
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship											
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship											
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship											
Dependent Name: First, Middle, Last		Date of Birth:	Family Relationship											
■ Plan Selection at current monthly rate (Check One) "ADVANTAGE" OUR FULL SERVICE PLAN ☐ Member only \$10.58 ☐ Member + 1 Dependent \$15.31 ☐ Member + Family \$27.56 OR "EXAM+" OUR MOST AFFORDABLE ☐ Member only \$1.66 ☐ Member + 1 Dependent \$2.37 ☐ Member + Family \$4.22 I hereby authorize the CalPERS 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. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization. <tr><td colspan="5">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.</td></tr><tr><td colspan="4">Signature of Applicant: X</td><td>Date of Application:</td></tr>					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.					Signature of Applicant: X				Date of Application:
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.														
Signature of Applicant: X				Date of Application:										

Note: If you need to ADD ADDITIONAL DEPENDENTS, please attach another sheet of paper



Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

RETIRED

