ADD

# AD&D Application Form

1. Fill out application.
2. Sign and Date the form.
3. Mail 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** | Active |
|---|---|---|

Underwritten by: New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010
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

**I hereby apply for and authorize the necessary salary deductions for the premium to pay for Accidental Death and Dismemberment insurance under the terms of the Master Policy as follows:.**

| Full Name (print): | Birthdate: | SSN (Last 4): | Sex: ☐ Male ☐ Female |
|---|---|---|---|
| Address: | City: | State: | ZIP: |

| Phone: | E-mail: | Occupation or Position: |
|---|---|---|
| Beneficiary: | Relationship: | Beneficiary SSN: / Beneficiary Occupation: |
| Beneficiary Address: | Amount of Principal Sum: See Price List $ | Monthly Premium: See Price List $ |

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***

* Applicant will be Spouse's and Dependent's beneficiary

**Amount of Insurance** - Spouse and Children covered only if Family Plan is checked

| ■ **Member** | ■ **Spouse** | ■ **Each Child** |
|---|---|---|
| 100% of Principal Sum | 60% of Principal Sum (if NO children)<br>50% of Principal Sum (if children) | 15% of Principal Sum (if spouse)<br>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 New York Life Insurance 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:** |
|---|---|

Policy Number: **G-29312-0 GMA-GI** 9/09ed

ACTIVE