Here are your Active Member Applications

ADD ACCIDENTAL DEATH & DISMEMBERMENT:
Active

GS GOLD SHIELD:
Active

PB PIGGYBACK:
Active

STL SUPPLEMENTAL TERM LIFE:
Guarantee Issue
Active

APP BENEFICIARY CHANGE FORM

CCPOA MEMBERSHIP:
please contact CCPOA Membership directly at **membership@ccpoa.org** or call **1-800-821-6443**

TRUST WEBSITE

CCPOA Benefit Trust Fund | (916) 779-6300 | www.ccpoabtf.org

These programs are only open to dues paying CCPOA members in good standing

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) 50% of Principal Sum (if children)	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 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

GS Gold Shield Disability 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

Application Gold Shield Disability Benefit Plan

Active

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

Phone:

E-mail:

Institution: Watch: ☐ 1st ☐ 2nd ☐ 3rd

■ **Plan Selection** at current monthly rate All Rates effective 07/01/2019

☐ **GOLD SHIELD** $55.00/mo

☐ **New Officer Special Offer**
$27.50/mo 1st year Gold Shield

Date of Graduation: (Must be within 90 days to qualify)

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.

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:

	YES	NO		YES	NO
A. The brain, nervous system, epilepsy, Parkinson's disease, stroke, mental or nervous disorder?	☐	☐	F. The endocrine system including diabetes, thyroid or adrenal disorders?	☐	☐
B. The respiratory system including tuberculosis, emphysema or COPD?	☐	☐	G. Cancer, tumor, Hodgkin's disease, leukemia, muscle disorders including Muscular Dystrophy or Multiple Sclerosis?	☐	☐
C. The heart, heart attack, heart murmur, blood, anemia, high blood pressure, rheumatic fever or vascular disease?	☐	☐	H. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV or any other immune deficiency disorder?	☐	☐
D. The gastrointestinal tracts, stomach, gall bladder, liver, hepatitis or pancreas disorders?	☐	☐	I. Bone Disease or bone injuries including fractures?	☐	☐
E. The genito-urinary system, kidneys, reproductive organs including prostatitis or uterine fibroids?	☐	☐	J. Any injury, disease, condition or abnormality not mentioned above?	☐	☐
K. Are you actively working within the duties of your occupation?				☐	☐

"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."

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.

AUTHORIZATION: I understand that I will be required to sign a release of medical information provided to me by the Trust Office to determine eligibility for participation in and/or benefits under the Disability Benefit Plan. If my application for participation in the Disability Benefit Program is approved my signature serves as my express written authorization of payroll deductions for the coverage I have elected at the rate in force until I notify the Trust in writing to discontinue deductions, or otherwise cease to be eligible to participate. **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.

ACTIVE

Signature of Applicant:

X

Date of Application:

PB

Piggyback 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

Application **CCPOA Piggyback Program**

Active

CCPOA Benefit Trust Fund (916) 779-6300

Full Name (Print):	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female

Address:

City:	State:	ZIP:

E-mail:

Phone:

■ **Plan Selection** at current monthly rate (Check One)

☐ Active Member Only $16.00

☐ Active Member and one or more dependents $28.00

ACTIVE

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 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.

List below names and birth dates of spouse and all dependent children under 26 years of age. (Birth dates are required)

First Middle Last	Date of Birth			Family Relationship

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

Change of Beneficiary Request

CCPOA Member Information

Member Name			Social Security Number (Last 4)
Address	City		State / ZIP
Institution		Home / Cell Phone	

Primary Beneficiary Name(s): *If more than one beneficiary is listed the total percentage must equal 100%*

Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City		State	Zip Code
Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City		State	Zip Code
Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City		State	Zip Code

Contingent Beneficiary Name(s): *If more than one beneficiary is listed the total percentage must equal 100%.*

Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City		State	Zip Code
Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City		State	Zip Code

Please check all boxes this change applies to:	
ACTIVE MEMBERS	**RETIRED MEMBERS**
☐ Active Base Life	☐ Retired Base Life
☐ Supplemental Term Life	☐ Retired Term Life
☐ AD&D	☐ Retired AD&D
☐ Accidental Death $5,000	☐ Senior Term Life

_____ _____

Signature Date

Mail to: CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235
Phone: 800.468.6486 | 916.779.6300 | Fax: 916.779.6355