

Supplemental Term Life Applications



For **CCPOA Rank & File** / **Supervisory Members**

New C/Os & Active Members

- Guarantee Issue Application
- Active Member Application



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

NOTICE TO CALIFORNIA INSURED

We are the Plan Administrator for your insurance coverage with New York Life Insurance Company.

If you need assistance, please contact us at:

California Correctional Peace Officers Association Benefit Trust Fund

2515 Venture Oaks Way, Suite 200

Sacramento, CA 95833-4235

Telephone: (800) 468-6486

The address and toll-free number for the Consumer Affairs Unit of the California Department of Insurance is:

Consumer Services and Market Conduct Branch

Consumer Services Division

300 South Spring Street, South Tower

Los Angeles, CA 90013

Telephone: (800) 927-4357 (HELP)

However, the Department of Insurance has requested that we inform you that they are to be contacted only if discussions with us have failed to produce a resolution to the problem that is satisfactory to you.

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.

ERISA DISCLAIMER:

Please be aware that, depending on your circumstances and the product(s) you select, your group benefits plan may be subject to the Employee Retirement Income Security Act of 1974 ("ERISA").

You should consult your tax and legal advisors regarding the applicability of ERISA to any arrangements addressed in this material. New York Life, its subsidiaries, agents, and employees do not provide legal, tax, or ERISA advice.

The tax consequences of benefits paid under this policy may depend on whether the employee pays for the coverage and to what extent the coverage is paid for on a pre- or post-tax basis, among other factors. Certain requirements apply to coverage offered under "cafeteria plans" subject to IRS sec. 125, including minimum eligibility and participation requirements. You should discuss with your tax advisor the consequences of buying this policy, including whether premium payments are deductible, the taxability of benefits; and whether you have met all applicable tax requirements. New York Life Insurance Company, its employees, agents, and affiliates cannot provide tax advice.

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

STL New Officers Only

GROUP SUPPLEMENTAL TERM LIFE INSURANCE

Guarantee Issue Plan

Please complete and return this form to the Benefit Trust Fund



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:	
Guarantee Issue Supplemental Term Life – Indicate N/A if Dependent Coverage is not desired					
Member Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Benefit Amount: \$125,000	Monthly Premium:	
Spouse Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female		12,500		
Children:	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 15 days - 6 months of age \$750 <input type="checkbox"/> 6 months or older \$7,500	\$1.65 per family/ per month	
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 15 days - 6 months of age \$750 <input type="checkbox"/> 6 months or older \$7,500		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 15 days - 6 months of age \$750 <input type="checkbox"/> 6 months or older \$7,500		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 15 days - 6 months of age \$750 <input type="checkbox"/> 6 months or older \$7,500		
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> 15 days - 6 months of age \$750 <input type="checkbox"/> 6 months or older \$7,500		
Hire Date:			Total Premium:		

Note: If you are covered as a member, you cannot be covered as a dependent of another member.

<p>Please check “Yes” or “No” By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance?</p>	<p>Member: <input type="checkbox"/> YES <input type="checkbox"/> NO Spouse: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>				
<p>Do you have other life insurance in force? If “Yes” total amount in all companies:</p>	<p>Member: \$ _____ Spouse: \$ _____</p>				
<p>Do you have other insurance applications pending? If “Yes” indicate amount and company.</p>	<p>Member: \$ _____ Company: _____ Spouse: \$ _____ Company: _____</p>				
<p>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.</p>					
<p>I have read and understand the conditions and exclusions of this group term life insurance plan. I understand that my coverage will be effective the first day of the month immediately following the month for which a payroll deduction is received for the Supplemental Term Life premium, provided that I am actively at work and a CCPOA member on that date. I also understand that the coverage afforded will be guaranteed issue to me based on the statements I have set forth.</p>					
<p>NAMING YOUR BENEFICIARY</p> <p>It is important that your beneficiary designation be clear so that there will be no question as to your meaning. When naming your beneficiary(ies) please include their full name, address, relationship to you, and if a minor, the age of that minor. If the beneficiary is not related to you either by blood or marriage, insert the words “Not Related.” The beneficiary box is on the front of this form.</p> <p>If you need assistance, contact the Trust at 1-800-In-Unit-6.</p> <p><i>Following are examples of the most common designations:</i></p> <ul style="list-style-type: none"> •Mary J. Doe, Wife. (not Mrs. John Doe) •Mary J. Doe, Wife, if living, otherwise to Joe W. Doe, Son. •Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joe W. Doe, Son, in equal shares, or to the survivor. •Estate of the Insured. •If you name more than one beneficiary with unequal share, please show the amount of insurance to be paid to each beneficiary in fractional parts. For example: “1/3 to Mary Jones, Mother, and 2/3 to Edith Jones, Wife”. 					
<p>By signing and dating this application, I and my spouse/domestic partner (if proposed for insurance), request the insurance indicated, understand the effective date criteria, and attest to having read the Fraud Notice indicated above, and 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.</p>					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="height: 40px; vertical-align: top; padding: 2px;">Member Signature</td> <td style="height: 40px; vertical-align: top; padding: 2px;">Date</td> </tr> <tr> <td style="height: 40px; vertical-align: top; padding: 2px;">Spouse Signature (if enrolling)</td> <td style="height: 40px; vertical-align: top; padding: 2px;">Date</td> </tr> </table>	Member Signature	Date	Spouse Signature (if enrolling)	Date	
Member Signature	Date				
Spouse Signature (if enrolling)	Date				
<p>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.</p>					



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

STL

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:	
<i>The Proposed Insured will be the beneficiary for any Dependent Coverage desired.</i>				
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 Office Use Only _____		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 _____		
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 <input type="checkbox"/>	NO <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"/>
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"/>

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 – 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 & 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, LLC. ("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, LLC.; 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.

Information from New York Life

IMPORTANT NOTICE:

How New York Life Insurance Company Obtains Information and Underwrites Your Request For Group Supplemental Term Life Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, LLC. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing, however, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, LLC., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: Protected persons¹ have a right of access to certain **Confidential abuse information²** we maintain in our files and they may choose to receive such information directly. You have the right to register as a **Protected person** by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.

- 1. Protected person** means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.
- 2. Confidential abuse information** means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company

7.13 ed.



We've Got You Covered.
(916) 779-6300
1-800-468-6486



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Effective January, 2026