Here are your Retired Member Applications

ADD ACCIDENTAL DEATH & DISMEMBERMENT:
Retired

PB PIGGYBACK:
Retired

STL SUPPLEMENTAL TERM LIFE:
Retired
Retired Roll-Over

LP MetLife – BTF Legal Plan:
Retired

VSP VSP:
Retired

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 Retired 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** — **Retired**

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 CalPERS to deduct from my retirement benefit the necessary deductions for the premium to pay for Accidental Death and Dismemberment insurance under the terms of the Master Policy as follows. I understand that there are benefit reductions at attainment of certain ages. (See the brochure for more information.)

Full Name (print):	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female
Address:	City:	State:	ZIP:
Phone:	E-mail:		
Beneficiary:	Relationship:	Beneficiary SSN:	
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	50% of Principal Sum (if NO children) 40% of Principal Sum (if children)	10% of Principal Sum (if spouse) 15% 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-29313-0 GMA-GI** 9/09ed

RETIRED

PB Piggyback Retired Application Form

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

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Application CCPOA Piggyback Program

Retired

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)

RETIRED

☐ 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 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

MetLife Legal Plan: Retired Application Form

1. Fill out application.
2. Sign and Date the form.
3. Mail 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 Legal Plan — 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:		

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

☐ **MetLife Legal Plan** $13.99/mo

Excludes Legal Defense Fund Benefits

RETIRED

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.

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:

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.

VSP Retired Application Form

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

vsp vision care

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

E-mail:

Phone:

Plan Selection at current monthly rate (Check One)

"FULL SERVICE" OUR STANDARD PLAN *OR* "EXAM+" OUR MOST AFFORDABLE

- ☐ Member only $8.84
- ☐ Member + 1 Dependent . . .$12.67
- ☐ Member + Family $22.61
- ☐ Member only $1.91
- ☐ Member + 1 Dependent $2.62
- ☐ Member + Family $4.47

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 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

RETIRED

Date of Application:

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

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.

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