ADD AD&D: 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**	**Active**

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

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 REQUESTED: $_____
See Back for Rate Chart

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)w	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:	**Date of Application:**
X	

MetLife

ACTIVE

ADD

AD&D: 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: $0.050/$1,000 Family: $0.060/$1,000	

SAMPLE RATE CHART: Monthly Premium

	$25,000	$50,000	$100,000	$500,000	$1,000,000
Member Only	$1.25	$2.50	$5.00	$25.00	$50.00
Family	$1.50	$3.00	$6.00	$30.00	$60.00

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	1.25	1.50
50,000	2.50	3.00
75,000	3.75	4.50
100,000	5.00	6.00
125,000	6.25	7.50
150,000	7.50	9.00
175,000	8.75	10.50
200,000	10.00	12.00
225,000	11.25	13.50
250,000	12.50	15.00
275,000	13.75	16.50
300,000	15.00	18.00
325,000	16.25	19.50
350,000	17.50	21.00
375,000	18.75	22.50
400,000	20.00	24.00
425,000	21.25	25.50
450,000	22.50	27.00
475,000	23.75	28.50
500,000	25.00	30.00

AD&D MONTHLY PREMIUM		
	Member Only	Family
525,000	26.25	31.50
550,000	27.50	33.00
575,000	28.75	34.50
600,000	30.00	36.00
625,000	31.25	37.50
650,000	32.50	39.00
675,000	33.75	40.50
700,000	35.00	42.00
725,000	36.25	43.50
750,000	37.50	45.00
775,000	38.75	46.50
800,000	40.00	48.00
825,000	41.25	49.50
850,000	42.50	51.00
875,000	43.75	52.50
900,000	45.00	54.00
925,000	46.25	55.50
950,000	47.50	57.00
975,000	48.75	58.50
1,000,000	50.00	60.00

CI Critical Illness: 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**

Request for Group Insurance from:	**Group Critical Illness Insurance**	**Active**

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

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** ☐ **Member + Spouse** ☐ **Member + Child(ren)** ☐ **Member + Family**

AMOUNT REQUESTED: $_____

MONTHLY PREMIUM: $_____

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:**

CI Critical Illness: Rate Charts

COVERAGE AMOUNT:

Amount of Insurance - Spouse and Children covered only if appropriate Plan is checked on front of application	
Four levels of coverage are available: **Member; Member+ Spouse; Member+Child(ren); Member+Family** Available to Active Members Only	
Rates are based on per $1,000 of coverage. Rates are in $10K increments, up to $50K Max	Member Only: Plans start at $0.46/$1,000 of coverage Family: Plans start at $1.39/$1,000 of coverage

Premiums shown are calculated by multiplying the rate per $1,000 by the selected coverage amount.

CRITICAL ILLNESS - MEMBER ONLY

	Price per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000
<25	$0.46	$4.60	$9.20	$13.80	$18.40	$23.00
25-29	$0.50	$5.00	$10.00	$15.00	$20.00	$25.00
30-34	$0.55	$5.50	$11.00	$16.50	$22.00	$27.50
35-39	$0.69	$6.90	$13.80	$20.70	$27.60	$34.50
40-44	$0.89	$8.90	$17.80	$26.70	$35.60	$44.50
45-49	$1.20	$12.00	$24.00	$36.00	$48.00	$60.00
50-54	$1.72	$17.20	$34.40	$51.60	$68.80	$86.00
55-59	$2.45	$24.50	$49.00	$73.50	$98.00	$122.50
60-64	$3.27	$32.70	$65.40	$98.10	$130.80	$163.50
65-69	$4.12	$41.20	$82.40	$123.60	$164.80	$206.00
70-74	$5.34	$53.40	$106.80	$160.20	$213.60	$267.00
75+	$7.10	$71.00	$142.00	$213.00	$284.00	$355.00

CRITICAL ILLNESS - MEMBER + SPOUSE

	Price per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000
<25	$0.93	$9.30	$18.60	$27.90	$37.20	$46.50
25-29	$1.02	$10.20	$20.40	$30.60	$40.80	$51.00
30-34	$1.12	$11.20	$22.40	$33.60	$44.80	$56.00
35-39	$1.44	$14.40	$28.80	$43.20	$57.60	$72.00
40-44	$1.87	$18.70	$37.40	$56.10	$74.80	$93.50
45-49	$2.46	$24.60	$49.20	$73.80	$98.40	$123.00
50-54	$3.34	$33.40	$66.80	$100.20	$133.60	$167.00
55-59	$4.57	$45.70	$91.40	$137.10	$182.80	$228.50
60-64	$5.93	$59.30	$118.60	$177.90	$237.20	$296.50
65-69	$7.46	$74.60	$149.20	$223.80	$298.40	$373.00
70-74	$9.69	$96.90	$193.80	$290.70	$387.60	$484.50
75+	$13.20	$132.00	$264.00	$396.00	$528.00	$660.00

CRITICAL ILLNESS - MEMBER + CHILD(REN)

	Price per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000
<25	$0.90	$9.00	$18.00	$27.00	$36.00	$45.00
25-29	$0.94	$9.40	$18.80	$28.20	$37.60	$47.00
30-34	$0.99	$9.90	$19.80	$29.70	$39.60	$49.50
35-39	$1.13	$11.30	$22.60	$33.90	$45.20	$56.50
40-44	$1.34	$13.40	$26.80	$40.20	$53.60	$67.00
45-49	$1.64	$16.40	$32.80	$49.20	$65.60	$82.00
50-54	$2.17	$21.70	$43.40	$65.10	$86.80	$108.50
55-59	$2.90	$29.00	$58.00	$87.00	$116.00	$145.00
60-64	$3.72	$37.20	$74.40	$111.60	$148.80	$186.00
65-69	$4.57	$45.70	$91.40	$137.10	$182.80	$228.50
70-74	$5.79	$57.90	$115.80	$173.70	$231.60	$289.50
75+	$7.55	$75.50	$151.00	$226.50	$302.00	$377.50

CRITICAL ILLNESS - MEMBER + SPOUSE & CHILD(REN)

	Price per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000
<25	$1.37	$13.70	$27.40	$41.10	$54.80	$68.50
25-29	$1.46	$14.60	$29.20	$43.80	$58.40	$73.00
30-34	$1.56	$15.60	$31.20	$46.80	$62.40	$78.00
35-39	$1.88	$18.80	$37.60	$56.40	$75.20	$94.00
40-44	$2.32	$23.20	$46.40	$69.60	$92.80	$116.00
45-49	$2.91	$29.10	$58.20	$87.30	$116.40	$145.50
50-54	$3.78	$37.80	$75.60	$113.40	$151.20	$189.00
55-59	$5.02	$50.20	$100.40	$150.60	$200.80	$251.00
60-64	$6.38	$63.80	$127.60	$191.40	$255.20	$319.00
65-69	$7.91	$79.10	$158.20	$237.30	$316.40	$395.50
70-74	$10.14	$101.40	$202.80	$304.20	$405.60	$507.00
75+	$13.64	$136.40	$272.80	$409.20	$545.60	$682.00

GS Gold Shield Disability 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 **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.

Signature of Applicant:	**Date of Application:**
X	

Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

ACTIVE

Hospital Indemnity: 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**

Request for Group Insurance from:	**Group Hospital Indemnity Insurance**	**Active**

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

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 - $14.25**/mo ☐ **Member + Spouse - $38.74**/mo ☐ **Member + Child(ren) - $28.21**/mo ☐ **Member + Family - $52.69**/mo

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:	**Date of Application:**
X	

PB

Piggyback 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 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

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

Benefit Trust Fund

COVERING THE MEMBERS OF CCPOA

ACTIVE

STL Active Supplemental 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**

Request for Group Insurance from:	**Active Term Life**	**Active**

Underwritten by: Metropolitan Life Insurance Company I 200 Park Avenue I 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: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			

The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

For Active 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 Active 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 Active Supplemental 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 iwn 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:**

Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

ACTIVE

STL Active Supplemental Term Life: Member Rate Information

MetLife Active Member Life Rates/monthly											
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$25,000	$1.00	$1.00	$1.00	$1.25	$1.50	$2.25	$3.25	$6.00	$9.25	$15.00	$22.50
$50,000	$2.00	$2.00	$2.00	$2.50	$3.00	$4.50	$6.50	$12.00	$18.50	$30.00	$45.00
$75,000	$3.00	$3.00	$3.00	$3.75	$4.50	$6.75	$9.75	$18.00	$27.75	$45.00	$67.50
$100,000	$4.00	$4.00	$4.00	$5.00	$6.00	$9.00	$13.00	$24.00	$37.00	$60.00	$90.00
$125,000	$5.00	$5.00	$5.00	$6.25	$7.50	$11.25	$16.25	$30.00	$46.25	$75.00	$112.50
$150,000	$6.00	$6.00	$6.00	$7.50	$9.00	$13.50	$19.50	$36.00	$55.50	$90.00	$135.00
$175,000	$7.00	$7.00	$7.00	$8.75	$10.50	$15.75	$22.75	$42.00	$64.75	$105.00	$157.50
$200,000	$8.00	$8.00	$8.00	$10.00	$12.00	$18.00	$26.00	$48.00	$74.00	$120.00	$180.00
$225,000	$9.00	$9.00	$9.00	$11.25	$13.50	$20.25	$29.25	$54.00	$83.25	$135.00	$202.50
$250,000	$10.00	$10.00	$10.00	$12.50	$15.00	$22.50	$32.50	$60.00	$92.50	$150.00	$225.00
$275,000	$11.00	$11.00	$11.00	$13.75	$16.50	$24.75	$35.75	$66.00	$101.75	$165.00	$247.50
$300,000	$12.00	$12.00	$12.00	$15.00	$18.00	$27.00	$39.00	$72.00	$111.00	$180.00	$270.00
$325,000	$13.00	$13.00	$13.00	$16.25	$19.50	$29.25	$42.25	$78.00	$120.25	$195.00	$292.50
$350,000	$14.00	$14.00	$14.00	$17.50	$21.00	$31.50	$45.50	$84.00	$129.50	$210.00	$315.00
$375,000	$15.00	$15.00	$15.00	$18.75	$22.50	$33.75	$48.75	$90.00	$138.75	$225.00	$337.50
$400,000	$16.00	$16.00	$16.00	$20.00	$24.00	$36.00	$52.00	$96.00	$148.00	$240.00	$360.00
$425,000	$17.00	$17.00	$17.00	$21.25	$25.50	$38.25	$55.25	$102.00	$157.25	$255.00	$382.50
$450,000	$18.00	$18.00	$18.00	$22.50	$27.00	$40.50	$58.50	$108.00	$166.50	$270.00	$405.00
$475,000	$19.00	$19.00	$19.00	$23.75	$28.50	$42.75	$61.75	$114.00	$175.75	$285.00	$427.50
$500,000	$20.00	$20.00	$20.00	$25.00	$30.00	$45.00	$65.00	$120.00	$185.00	$300.00	$450.00
$525,000	$21.00	$21.00	$21.00	$26.25	$31.50	$47.25	$68.25	$126.00	$194.25	$315.00	$472.50
$550,000	$22.00	$22.00	$22.00	$27.50	$33.00	$49.50	$71.50	$132.00	$203.50	$330.00	$495.00
$575,000	$23.00	$23.00	$23.00	$28.75	$34.50	$51.75	$74.75	$138.00	$212.75	$345.00	$517.50
$600,000	$24.00	$24.00	$24.00	$30.00	$36.00	$54.00	$78.00	$144.00	$222.00	$360.00	$540.00
$625,000	$25.00	$25.00	$25.00	$31.25	$37.50	$56.25	$81.25	$150.00	$231.25	$375.00	$562.50
$650,000	$26.00	$26.00	$26.00	$32.50	$39.00	$58.50	$84.50	$156.00	$240.50	$390.00	$585.00
$675,000	$27.00	$27.00	$27.00	$33.75	$40.50	$60.75	$87.75	$162.00	$249.75	$405.00	$607.50
$700,000	$28.00	$28.00	$28.00	$35.00	$42.00	$63.00	$91.00	$168.00	$259.00	$420.00	$630.00
$725,000	$29.00	$29.00	$29.00	$36.25	$43.50	$65.25	$94.25	$174.00	$268.25	$435.00	$652.50
$750,000	$30.00	$30.00	$30.00	$37.50	$45.00	$67.50	$97.50	$180.00	$277.50	$450.00	$675.00
$775,000	$31.00	$31.00	$31.00	$38.75	$46.50	$69.75	$100.75	$186.00	$286.75	$465.00	$697.50
$800,000	$32.00	$32.00	$32.00	$40.00	$48.00	$72.00	$104.00	$192.00	$296.00	$480.00	$720.00
$825,000	$33.00	$33.00	$33.00	$41.25	$49.50	$74.25	$107.25	$198.00	$305.25	$495.00	$742.50
$850,000	$34.00	$34.00	$34.00	$42.50	$51.00	$76.50	$110.50	$204.00	$314.50	$510.00	$765.00
$875,000	$35.00	$35.00	$35.00	$43.75	$52.50	$78.75	$113.75	$210.00	$323.75	$525.00	$787.50
$900,000	$36.00	$36.00	$36.00	$45.00	$54.00	$81.00	$117.00	$216.00	$333.00	$540.00	$810.00
$925,000	$37.00	$37.00	$37.00	$46.25	$55.50	$83.25	$120.25	$222.00	$342.25	$555.00	$832.50
$950,000	$38.00	$38.00	$38.00	$47.50	$57.00	$85.50	$123.50	$228.00	$351.50	$570.00	$855.00
$975,000	$39.00	$39.00	$39.00	$48.75	$58.50	$87.75	$126.75	$234.00	$360.75	$585.00	$877.50
$1,000,000	$40.00	$40.00	$40.00	$50.00	$60.00	$90.00	$130.00	$240.00	$370.00	$600.00	$900.00

STL Active Supplemental Term Life: Spouse Rate Information

MetLife Active Spouse Life Rates/monthly											
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$12,500	$0.50	$0.50	$0.50	$0.63	$0.88	$1.25	$1.63	$3.00	$5.00	$7.75	$12.50
$25,000	$1.00	$1.00	$1.00	$1.25	$1.75	$2.50	$3.25	$6.00	$10.00	$15.50	$25.00
$37,500	$1.50	$1.50	$1.50	$1.88	$2.63	$3.75	$4.88	$9.00	$15.00	$23.25	$37.50
$50,000	$2.00	$2.00	$2.00	$2.50	$3.50	$5.00	$6.50	$12.00	$20.00	$31.00	$50.00
$62,500	$2.50	$2.50	$2.50	$3.13	$4.38	$6.25	$8.13	$15.00	$25.00	$38.75	$62.50
$75,000	$3.00	$3.00	$3.00	$3.75	$5.25	$7.50	$9.75	$18.00	$30.00	$46.50	$75.00
$87,500	$3.50	$3.50	$3.50	$4.38	$6.13	$8.75	$11.38	$21.00	$35.00	$54.25	$87.50
$100,000	$4.00	$4.00	$4.00	$5.00	$7.00	$10.00	$13.00	$24.00	$40.00	$62.00	$100.00
$112,500	$4.50	$4.50	$4.50	$5.63	$7.88	$11.25	$14.63	$27.00	$45.00	$69.75	$112.50
$125,000	$5.00	$5.00	$5.00	$6.25	$8.75	$12.50	$16.25	$30.00	$50.00	$77.50	$125.00
$137,500	$5.50	$5.50	$5.50	$6.88	$9.63	$13.75	$17.88	$33.00	$55.00	$85.25	$137.50
$150,000	$6.00	$6.00	$6.00	$7.50	$10.50	$15.00	$19.50	$36.00	$60.00	$93.00	$150.00
$162,500	$6.50	$6.50	$6.50	$8.13	$11.38	$16.25	$21.13	$39.00	$65.00	$100.75	$162.50
$175,000	$7.00	$7.00	$7.00	$8.75	$12.25	$17.50	$22.75	$42.00	$70.00	$108.50	$175.00
$187,500	$7.50	$7.50	$7.50	$9.38	$13.13	$18.75	$24.38	$45.00	$75.00	$116.25	$187.50
$200,000	$8.00	$8.00	$8.00	$10.00	$14.00	$20.00	$26.00	$48.00	$80.00	$124.00	$200.00
$212,500	$8.50	$8.50	$8.50	$10.63	$14.88	$21.25	$27.63	$51.00	$85.00	$131.75	$212.50
$225,000	$9.00	$9.00	$9.00	$11.25	$15.75	$22.50	$29.25	$54.00	$90.00	$139.50	$225.00
$237,500	$9.50	$9.50	$9.50	$11.88	$16.63	$23.75	$30.88	$57.00	$95.00	$147.25	$237.50
$250,000	$10.00	$10.00	$10.00	$12.50	$17.50	$25.00	$32.50	$60.00	$100.00	$155.00	$250.00

Child Benefit/monthly	
	Birth up to Age 26
$10,000	$1.65

MetLife

ACTIVE

STL Guarantee Issue: Supplemental 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**

Request for Group Insurance from:	**Guarantee Issue Insurance**	**Active**

Underwritten by: Metropolitan Life Insurance Company I 200 Park Avenue I 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: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			

The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

For Active CCPOA Member

I hereby apply for a **Guarantee Issue benefit amount** of:

$_____

($25,000 minimum up to $200,000 maximum in $25,000 increments. See rate chart.)

☐ New Coverage

For Active CCPOA Member's Spouse

I hereby apply for a **Guarantee Issue benefit amount** of:

$_____

($12,500 minimum up to $100,000 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

MetLife Guarantee Issue: Active Member Rates/monthly

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$25,000	$1.00	$1.00	$1.00	$1.25	$1.50	$2.25	$3.25	$6.00	$9.25	$15.00	$22.50
$50,000	$2.00	$2.00	$2.00	$2.50	$3.00	$4.50	$6.50	$12.00	$18.50	$30.00	$45.00
$75,000	$3.00	$3.00	$3.00	$3.75	$4.50	$6.75	$9.75	$18.00	$27.75	$45.00	$67.50
$100,000	$4.00	$4.00	$4.00	$5.00	$6.00	$9.00	$13.00	$24.00	$37.00	$60.00	$90.00
$125,000	$5.00	$5.00	$5.00	$6.25	$7.50	$11.25	$16.25	$30.00	$46.25	$75.00	$112.50
$150,000	$6.00	$6.00	$6.00	$7.50	$9.00	$13.50	$19.50	$36.00	$55.50	$90.00	$135.00
$175,000	$7.00	$7.00	$7.00	$8.75	$10.50	$15.75	$22.75	$42.00	$64.75	$105.00	$157.50
$200,000	$8.00	$8.00	$8.00	$10.00	$12.00	$18.00	$26.00	$48.00	$74.00	$120.00	$180.00

MetLife Guarantee Issue: Active Spouse Life Rates/monthly

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$12,500	$0.50	$0.50	$0.50	$0.63	$0.88	$1.25	$1.63	$3.00	$5.00	$7.75	$12.50
$25,000	$1.00	$1.00	$1.00	$1.25	$1.75	$2.50	$3.25	$6.00	$10.00	$15.50	$25.00
$37,500	$1.50	$1.50	$1.50	$1.88	$2.63	$3.75	$4.88	$9.00	$15.00	$23.25	$37.50
$50,000	$2.00	$2.00	$2.00	$2.50	$3.50	$5.00	$6.50	$12.00	$20.00	$31.00	$50.00
$62,500	$2.50	$2.50	$2.50	$3.13	$4.38	$6.25	$8.13	$15.00	$25.00	$38.75	$62.50
$75,000	$3.00	$3.00	$3.00	$3.75	$5.25	$7.50	$9.75	$18.00	$30.00	$46.50	$75.00
$87,500	$3.50	$3.50	$3.50	$4.38	$6.13	$8.75	$11.38	$21.00	$35.00	$54.25	$87.50
$100,000	$4.00	$4.00	$4.00	$5.00	$7.00	$10.00	$13.00	$24.00	$40.00	$62.00	$100.00

Child Benefit/monthly

	Birth up to Age 26
$10,000	$1.65

Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

ACTIVE