

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: <input type="checkbox"/> Male <input type="checkbox"/> Female																																				
Address:				<div> <p>List below names and birth dates of spouse and all dependent children under 26 years of age. (Birth dates are required)</p> <table border="1"> <thead> <tr> <th>First</th> <th>Middle</th> <th>Last</th> <th>Date of Birth</th> <th>Family Relationship</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> </div>				First	Middle	Last	Date of Birth	Family Relationship																														
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City:	State:	ZIP:																																								
E-mail:																																										
Phone:																																										
<p>■ Plan Selection at current monthly rate (Check One)</p> <p><input type="checkbox"/> Active Member Only \$16.00</p> <p><input type="checkbox"/> Active Member and one or more dependents \$28.00</p> <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). 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.</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>																																										
Signature of Applicant:						Date of Application:																																				

ACTIVE

X

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