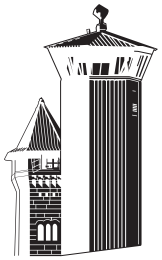
DBP

Disability Application Form

1. Print-out this form.
2. Fill out application.
3. Sign and Date the form.
4. Mail your application to:



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

Fold down and seal to return mail

Application **CCPOA Disability Benefit Plan** — Active

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

Phone:	Graduation Date (New Officer Only):
E-mail:	
Height:	Weight:

■ **Plan Selection** at current monthly rate (Check One)
☐ **GOLD SHIELD** $65.00/mo ☐ **SILVER SHIELD** $45.00/mo

☐ **New Officer Special Offer**
$32.50/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 or nervous system including epilepsy, dizziness, stroke, mental or nervous disorder?	☐	☐	F. The endocrine system including diabetes, thyroid or adrenal disorder?	☐	☐
B. The respiratory system including tuberculosis, asthma, emphysema or shortness of breath?	☐	☐	G. Cancer, tumor, arthritis, gout or disorder of joints, muscles or bones?	☐	☐
C. The heart, blood or blood vessels including heart attack, heart murmur, anemia, high blood pressure, chest pains, rheumatic fever, or hepatitis?	☐	☐	H. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV or any other immune deficiency disorder?	☐	☐
D. The gastrointestinal tract, liver, gall bladder, stomach, including ulcer or hernia?	☐	☐	I. Any physical defect or deformity including impaired vision, speech or hearing?	☐	☐
E. The genito-urinary system, kidneys, reproductive organs including prostatitis or uterine fibroids, albumin, blood or sugar in the urine?	☐	☐	J. Any injury, disease, condition, or abnormality not mentioned above, including, for example, bone injuries?	☐	☐
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."

ACTIVE

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.

Signature of Applicant: X

Date of Application:

Fold up and seal to return mail

We've Got You Covered.

1-800-In-Unit-6
1-800-468-6486

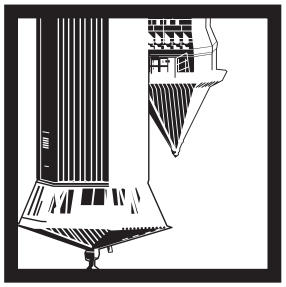
NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 149 SACRAMENTO, CA

POSTAGE WILL BE PAID BY ADDRESSEE

CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-9978

ACCEPT NO SUBSTITUTES



NO TOWERS?
NO TRUST

Tape Top Closed

Tape Top Closed