Disability coverage is the single most important plan you should have.

***New Graduates** - Sign up within **90 days** of graduation and get your first year of **Gold Shield** at **50% off**

YOU CAN'T SIGN UP AFTER THE FACT.

Every week we hear from CCPOA members who have been disabled, but never signed up for disability coverage through the Trust. Your chance of having a disability during your working years is a real threat to your financial future.

Take care of yourself by putting a disability plan in place. For most CCPOA members, that means long term protection - the Gold Shield Disability Benefit Plan.

Having disability coverage makes sense if you're a CCPOA member. It gives you a way to take care of yourself while disabled without wondering if you can put food on the table.

On-the-Job. Off-the-Job. 24/7/365

If you wonder if you can afford it, ask yourself if you can afford to be without it.

$65 monthly. Half that for New COs.*

The price of a dinner and a movie. *(Maybe less if you had a steak!)*

We know that great benefits are one of the things that attract people to this line of work.
Take advantage of them today.

Helps while your Workers' Comp benefits are pending

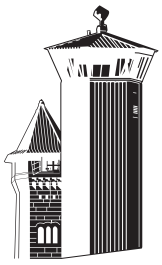
Gold Shield participants are provided with provisional benefit, above the basic minimum monthly benefit, while your Workers' Comp case is pending. If you win your case, you will receive a back-pay award from the Workers' Compensation Appeals Board. You use this money to repay the provisional benefit, still keeping each month's minimum benefit. If you lose your case, and you are otherwise eligible for benefits, you keep every dime.

No Age-Related Premiums

Age is not an issue. Whether you are 21 or 65 your payment is the same.

You would do anything for them. Get Gold Shield.

Questions? Call the Trust or go online.



CCPOA Benefit Trust Fund | 1-800-In-Unit-6 | www.ccpoabtf.org

Application **CCPOA Disability Benefit Plan** — Active

Full Name (print):	Birthdate:	SSN:	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: