Group Supplemental Term Life Insurance Coverage

Sponsored by the CCPOA Benefit Trust Fund

A Secure Future for Your Family

SUPPLEMENTAL TERM LIFE INSURANCE

SPONSORED BY
CCPOA BENEFIT TRUST FUND

UNDERWRITTEN BY
NEW YORK LIFE INSURANCE

- Protection at an affordable rate, including spouses and children
- Limited underwriting
- Same rates for males and females
- A "no cancellation" policy for ill health
- Accelerated death benefits option
- Premiums paid through convenient payroll deductions
- Carryover into retirement
- New - Spouse continuation benefit option

New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010
NAIC Number 66915

This brochure is intended to describe only principle features of the Group Supplemental Term Life Insurance coverage offered through the CCPOA Benefit Trust Fund, and is not a contract. A complete description including features, limitations, exclusions, rates and conditions is contained in the Certificate of Insurance issued to each plan participant. Benefits are provided under the Group Policy GMR – ER et. al, Policy Number G29307-0/FACE issued by New York Life Insurance Company to the CCPOA Benefit Trust Fund.

1.14.1401.05
STL ActBroch_2019.v1
Q218R09

Effective Date: January 2019 1664646

Because they depend on you.

If you have people who depend on you or your income, you should consider having life insurance.

Life insurance helps plan for your dependent's future financial needs, even if you're not around.

You get homeowners insurance to protect your home. Why shouldn't you get life insurance to help protect your family?

Life insurance coverage can help:

- Assure your children the education you've all dreamed of
- Pay off your mortgage or other family debts
- Cover ongoing daily expenses and bills once you're gone

If you're the sole provider in your family, having life insurance can be critical.

However, today many families depend on two incomes to meet their financial needs, and having life insurance on both wage earners has become increasingly important.

How Much Life Insurance Do You Need?

CCPOA presently provides each active member with basic $20,000 group term life insurance coverage. However, your family may need more.

There is no magic formula to determine how much life insurance you should have. Many financial professionals say that you need 5-6 times your annual income in life insurance.

There are a number of factors that should be considered when estimating how much life insurance you should carry, including final expenses, children's long-term education, re-education or retirement funds for surviving spouse, supplemental income to maintain mortgage payments, etc.

KEY Benefits

CARRY INTO RETIREMENT. Currently enrollees in this plan, who become a member of the CCPOA Retired Chapter, have the option of moving their coverage and the coverage on their insured spouse into the CCPOA retiree plan without medical evidence insurability, at active rates, by completing the Rollover Request within 90 days of retirement. Members who retire before age 60* may enroll for up to half of the coverage they and their insured spouse had on the date they retired. Member coverage cannot exceed $250,000 and spouse coverage is limited to a maximum of $50,000. Coverage reduces by half at ages 60 and by half again at age 70 (maximum $50,000). Premium rates are subject to change.

*Members who retire at ages 60 – 69 may request up to $125,000 (Spouse up to $25,000). Members who retire at ages 70 and over may request the lesser of $50,000 (Spouse up to $12,500).

No Cancellation for Ill Health. Once your coverage takes effect, you cannot be cancelled due to a change in your health.

ACCELERATED DEATH BENEFIT. Potentially relieves some of the financial difficulties associated with a terminal illness by allowing you (and your spouse, if covered) a one-time option to receive up to 50% of the term life insurance proceeds, to a maximum of $100,000, upon being diagnosed by a physician as having less than 12 months to live.*

30-DAY "FREE LOOK." You have 30 days to look over your new insurance program and discuss it with your family and advisors. If for any reason you're not satisfied, you may return your certificate within 30 days of your effective date of coverage for a full refund, minus any claims paid.

CONVERSION PRIVILEGE. If your coverage is terminated for any reason other than non-payment of premium or cancellation of the Master Policy, you may convert it to an individual policy customarily offered by New York Life, without providing further proof of your health. Conversion may be requested at any time up to 31 days after termination of your original coverage. This conversion privilege is also available to your insured spouse and/or children should you pass away. (See your Certificate of Insurance for more information).

*You should consult a personal tax advisor since proceeds under this benefit may be taxable.

Who's Eligible?

As an active CCPOA member under 75 and working full-time*, you can apply for coverage on yourself, your spouse, and your dependent children under age 21 years (23, if a full-time student).

If you and your spouse are both active members of CCPOA each of you may apply in your own right as a member, not solely as a spouse. If you do so, however, coverage may not be duplicated by applying as dependents of each other and only one of you may request coverage for eligible children.

This program is available to residents of California only. CCPOA and CCPOA Benefit Trust Fund staff are also eligible to apply. Permanent Intermittent Employees are eligible to participate in this Insurance Plan, including Term Life Insurance and Accidental Death & Dismemberment.

*Includes permanent full-time (actively at work at least 30 hours per week) and PIE employees, and all R06, S06, M06 CCPOA members.

When Is Coverage Effective?

Your coverage will be effective (subject to approval of your application by the CCPOA Benefit Trust Fund and New York Life Insurance), the first (1st) day of the next calendar month immediately following the month for which a payroll deduction is received for the Group Supplemental Term Life premium, provided that you are actively at work and a CCPOA member on that date.

If you choose to cover your dependents, their insurance will begin on the date you become covered, or the first month following approval of your application to cover a dependent, whichever date is later, subject to deduction of the required premium.

If you are not a CCPOA member or actively working full-time when coverage would normally take effect, the effective date will be deferred until you return to active full-time work and/or become a CCPOA member.

Please Note: Acceptance into this plan is subject to medical evidence of insurability as determined by New York Life Insurance. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

Deferred Effective Date: If you are not Actively-at-Work on the date you are to be covered under the Policy, you (and your spouse/dependents) will not be covered until the date you return to work.

Coverage

Benefits are paid for a death occurring at any time, any place,* from any cause, except suicide in the first two years.

When Does Coverage End?

Your coverage under this plan will terminate on:

- The date the policy is cancelled; or
- The Premium Due Date on or nearest the date you cease to be a dues paying member of the CCPOA; or
- The Premium payment is not made on the Due Date.

Your dependent's coverage remains in force as long as your coverage remains in effect, you are a member in good standing, and they remain eligible dependents.

Spouse Continuation Benefit Option: If you die, your spouse may continue receiving benefits through a special direct pay program available through the Trust. An eligible spouse cannot be legally separated or divorced from the insured person.

What Happens When You Retire?

Currently enrollees in this plan, who become a member of the CCPOA Retired Chapter, have the option of moving their coverage and the coverage on their insured spouse into the CCPOA retiree plan without medical evidence insurability, at active rates, by completing the Rollover Request within 90 days of retirement. Members who retire before age 60* may enroll for up to half of the coverage they and their insured spouse had on the date they retired. Member coverage cannot exceed $250,000 and spouse coverage is limited to a maximum of $50,000. Coverage reduces by half at ages 60 and by half again at age 70 (maximum $50,000). Premium rates are subject to change.

The coverage amount you have will stay the same until you reach 60, when the amount is reduced by half, but the premium rates will continue to be active rates. At age 70, the coverage amount is either reduced by half again or to $50,000 for you and to $12,500 for your spouse, whichever amount is less. The premium rates stay at active rates as long as you are a member of the CCPOA Retiree Chapter. For more information on Retiree coverage, you can obtain a copy by contacting the BTF.
(See rate chart next page.)

*Subject to U.S. Government regulations on restricted countries.

Information about choosing a minor beneficiary.

If at the insured's death, the named beneficiary of this insurance is a minor, the laws of most states require that a parent or guardian of the minors estate be appointed to receive the proceeds for the minor. Of course, the legal requirements of each state differ, and in some cases, New York Life may be permitted to pay nominal amounts directly to the minor beneficiary; but, as a general rule, we will require the appointment of a guardian in these situations.

We are giving you this information so that you will be aware of the delay in claims payment which may result from the need to have a guardian appointed.

If you have any question about the propriety of naming a minor as beneficiary of this insurance, you should consult your legal counsel.

Active Supplemental Term Life Rate Chart

Application on back page ▸

CURRENT MEMBER INDIVIDUAL MONTHLY PREMIUMS - Group Supplemental Term Life Insurance

AGE	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$25,000	1.50	1.75	2.00	2.50	3.75	5.75	10.75	16.25	25.75	39.00
$50,000	2.75	3.25	3.75	4.75	7.25	11.25	21.25	32.25	51.25	77.75
$75,000	4.00	4.75	5.50	7.00	10.75	16.75	31.75	48.25	76.75	116.50
$100,000	5.25	6.25	7.25	9.25	14.25	22.25	42.25	64.25	102.25	155.25
$125,000	6.50	7.75	9.00	11.50	17.75	27.75	52.75	80.25	127.75	194.00
$150,000	7.75	9.25	10.75	13.75	21.25	33.25	63.25	96.25	153.25	232.75
$175,000	9.00	10.75	12.50	16.00	24.75	38.75	73.75	112.25	178.75	271.50
$200,000	10.25	12.25	14.25	18.25	28.25	44.25	84.25	128.25	204.25	310.25
$225,000	11.50	13.75	16.00	20.50	31.75	49.75	94.75	144.25	229.75	349.00
$250,000	12.75	15.25	17.75	22.75	35.25	55.25	105.25	160.25	255.25	387.75
$275,000	14.00	16.75	19.50	25.00	38.75	60.75	115.75	176.25	280.75	426.50
$300,000	15.25	18.25	21.25	27.25	42.25	66.25	126.25	192.25	306.25	465.25
$325,000	16.50	19.75	23.00	29.50	45.75	71.75	136.75	208.25	331.75	504.00
$350,000	17.75	21.25	24.75	31.75	49.25	77.25	147.25	224.25	357.25	542.75
$375,000	19.00	22.75	26.50	34.00	52.75	82.75	157.75	240.25	382.75	581.50
$400,000	20.25	24.25	28.25	36.25	56.25	88.25	168.25	256.25	408.25	620.25
$425,000	21.50	25.75	30.00	38.50	59.75	93.75	178.75	272.25	433.75	659.00
$450,000	22.75	27.25	31.75	40.75	63.25	99.25	189.25	288.25	459.25	697.75
$475,000	24.00	28.75	33.50	43.00	66.75	104.75	199.75	304.25	484.75	736.50
$500,000	25.25	30.25	35.25	45.25	70.25	110.25	210.25	320.25	510.25	775.25

CURRENT SPOUSE INDIVIDUAL MONTHLY PREMIUMS - Group Supplemental Term Life Insurance

AGE	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-70	70-74
$12,500	0.75	0.84	1.00	1.38	2.00	2.63	3.25	7.88	12.25	20.00
$25,000	1.25	1.44	1.75	2.50	3.75	5.00	6.25	15.50	24.25	39.75
$37,500	1.75	2.03	2.50	3.63	5.50	7.38	9.25	23.13	36.25	59.50
$50,000	2.25	2.62	3.25	4.75	7.25	9.75	12.25	30.75	48.25	79.25

COVERAGE AMOUNT

The premiums shown reflect the current rates (as of January 1, 2013) and benefit structure. Premiums may be changed by New York Life on any premium due date, but not more than once in any 12-month period, and on any date on which benefits are changed. Your rate may change only if they are changed for all others in the same class of insureds under this group policy. For example, a class of insureds is a group of people with all the same issue age and gender. Premiums shown are payroll deducted and will increase on the premium due date coinciding with or next following the date that a member or spouse enters a new age bracket. Benefit option amounts are subject to change by agreement between New York Life and the Trustees.

Dependent CHILDREN MONTHLY PREMIUMS - Group Supplemental Term Life Insurance

$7,500	$1.65 / per family

Benefit Amount per child age 6 months – 21, or 23 if full time student. [$750 for children from 15 days old to 6 months.]

New officers and their spouse,age 55 and younger choosing the **Guarantee Issue Plan** can choose from amounts shown in red outline. Se our website for more information on the Guarantee Issue Plan.

Note: If you are covered as a member, you cannot be covered as a dependent of another member.

EXCLUSION: Suicide is excluded from coverage for the first two years, whether sane or insane. If a covered person does commit suicide within the first two years of coverage, New York Life will only pay an amount equal to the premium paid for coverage till the date of death. The Life Insurance Benefit is payable if a member is covered under the policy and commits suicide after the two year period.

The total amount of coverage an individual may request under all Group Life Insurance Plans underwritten by New York Life Insurance Company issued to the CCPOA-Benefit Trust Fund may not exceed $500,000 for active members, $50,000 for their spouses.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For Group Supplemental Term Life Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance , we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing, however, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901 (TTY 866 346-3642). For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: Protected persons[1] have a right of access to certain Confidential abuse information[2] we maintain in our files and they may choose to receive such information directly. You have the right to register as a Protected person by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.

1. *Protected person means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.*

2. *Confidential abuse information means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

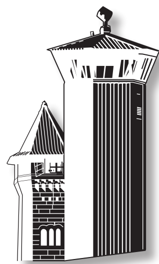
New York Life Insurance Company
8.12 ed.

New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010

We've Got You Covered.

1-800-In-Unit-6

1-800-468-6486



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

New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010
NAIC Number 66915

ERISA DISCLAIMER:

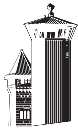
Please be aware that, depending on your circumstances and the product(s) you select, your group benefits plan may be subject to the Employee Retirement Income Security Act of 1974 ("ERISA").

You should consult your tax and legal advisors regarding the applicability of ERISA to any arrangements addressed in this material. New York Life, its subsidiaries, agents, and employees do not provide legal, tax, or ERISA advice.

The tax consequences of benefits paid under this policy may depend on whether the employee pays for the coverage and to what extent the coverage is paid for on a pre- or post-tax basis, among other factors. Certain requirements apply to coverage offered under "cafeteria plans" subject to IRS sec. 125, including minimum eligibility and participation requirements. You should discuss with your tax advisor the consequences of buying this policy, including whether premium payments are deductible, the taxability of benefits; and whether you have met all applicable tax requirements. New York Life Insurance Company, its employees, agents, and affiliates cannot provide tax advice.

1.14.1401.05
STL ActBroch_2019.v1
Q218R09

498395
Effective January, 2019



STL **CCPOA Active Members**

GROUP SUPPLEMENTAL TERM LIFE INSURANCE

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

Please complete and return this form to the Benefit Trust Fund

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010

Residents of New York please call the Trust at 1-800-468-6486 for a NY specific application.

Please Print Use Dark Ink Do Not Erase Initial All Changes.			Office Use:
Policyholder and Participating Organizations: **CCPOA Benefit Trust Fund**	Policy No. **G29307**	Height: Ft________In________ Weight: ____________lb	
CCPOA Members Name (First, Middle Initial, Last)		Date of Birth:	❏ Male ❏ Female
Street:		Phone No.:	Last 4 of SSN:
City:		State:	Zip:
Proposed Insured's Occupation and Facility:			

Beneficiary – Print full name & relationship to you	
Name (Primary):	Relationship:
Beneficiary Address:	Beneficiary SSN:
Name (Contingent):	Relationship:
Beneficiary Address:	Beneficiary SSN:

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

For CCPOA Member
I hereby apply for a **benefit amount** of:

$______________________
($25,000 minimum up to $500,000 maximum in $25,000 increments. See rate chart.)

☐ New Coverage ☐ Change in coverage
IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT TOTAL AMOUNT DESIRED

For Office Use Only____________________________________

For CCPOA Member's Spouse
I hereby apply for a **benefit amount** of:

$______________________
($12,500 minimum up to $50,000 maximum in increments of $12,500. The spouse benefit amount must be no greater than 50 percent of the member's coverage.)

Is spouse an Active or Retired CCPOA Member? Check box: ☐Yes *or* ☐No
☐ Coverage for dependent child(ren). $750/$7,500 benefit
IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT TOTAL AMOUNT DESIRED

For Office Use Only____________________________________

If Spouse/Dependent Coverage is desired, complete the following:

Full Name of Spouse/Dependent Children	Relationship	Birth Date	Height	Weight

Member Statement of Health:

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:		MEMBER		SPOUSE	
		YES	NO	YES	NO
A	Are you taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐	☐	☐	☐
B	During the past five years have you ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus, or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?	☐	☐	☐	☐
C	During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs?	☐	☐	☐	☐

Continued on next page

Details (please fill out if answered “YES” to A, B, or C)

____

Depending on the amount of insurance you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history.
What time and telephone number would be best to contact you? ____

Please check “Yes” or “No” By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance?	**Member:** ☐ YES ☐ NO **Spouse:** ☐ YES ☐ NO	
Do you have other life insurance in force? If “Yes” total amount in all companies:	**Member: $**________________	**Spouse: $**__________________
Do you have other insurance applications pending? If “Yes” indicate amount and company.	**Member: $**________________ **Company:** ________________	**Spouse: $**__________________ **Company:** _________________

FRAUD NOTICE – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

AUTHORIZATION & SIGNATURE: I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. (“MIB”), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, I member/spouse request the insurance indicated; and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE enclosed, including making a brief report of [my/our] protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE enclosed and Fraud Notice indicated above, including how [my/our] information is exchanged with MIB, and that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete.

Member Signature	Date
Spouse Signature (if enrolling)	Date

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 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.