Here are your application forms for Retired Members

STL

Supplemental Term Life from the Trust

Retired Members.

Coverage throughout your Career.

1. Fill out the Application.
2. Return to the Trust in the envelope provided.
3. Relax. We've Got You Covered.

Retired: Rollover your existing policy in the first 90 days of retirement with no gap in coverage.

We've Got You Covered.

1-800-In-Unit-6

NOTICE TO CALIFORNIA INSUREDS

We are the Plan Administrator for your insurance coverage with New York Life Insurance Company.

If you need assistance, please contact us at:

California Correctional Peace Officers Association Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

Telephone No.: 800 468-6486

The address and toll-free number for the Consumer Affairs Unit of the California Department of Insurance is:

Consumer Services and Market Conduct Branch
Consumer Services Division
300 South Spring Street, South Tower
Los Angeles, CA 90013
Telephone No: 1-800-927-4357 (HELP)

However, the Department of Insurance has requested that we inform you that they are to be contacted only if discussions with us have failed to produce a resolution to the problem that is satisfactory to you.

ALREADY RETIRED – USE THIS FORM

GROUP SUPPLEMENTAL TERM LIFE INSURANCE

CCPOA Retired Members

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

NEW YORK LIFE
THE COMPANY YOU KEEP®

Please Print Use Dark Ink Do Not Erase Initial All Changes.		Office Use:
Policyholder and Participating Organizations: **CCPOA Benefit Trust Fund**	Policy No. **G29310**	Height: Ft_____In_____ Weight:_____lb
CCPOA Member's Name (First, Middle Initial, Last)	Date of Birth:	❑ Male ❑ Female
Street:	Phone No.:	Last 4 of SSN:
City:	State:	Zip:

I am a CCPOA retired chapter member. I am seeking the Supplemental Term Life benefit listed below ❑ _____ (initial here)

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 Dependant Coverage desired.

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

$_____
($25,000 minimum up to $250,000 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 Retired 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% of the member's coverage.)

❑ Coverage for dependant child(ren). $750/$7,500 benefit
IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT TOTAL AMOUNT DESIRED

For Office Use Only_____

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

Full Name of Spouse/Dependant 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 dependants 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: Spouse:	❑ YES ❑ YES	❑ NO ❑ 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: _____

I understand that insurance will become effective for myself and any approved dependants, on the first of the month following the date approved by New York Life if the initial premium contribution has been received.

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

RETIRING AND HAVE TERM LIFE – USE THIS FORM

GROUP SUPPLEMENTAL TERM LIFE INSURANCE

Retired Rollover Members

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

NEW YORK LIFE
THE COMPANY YOU KEEP®

Please Print Use Dark Ink Do Not Erase Initial All Changes.
To continue coverage New York Life will rely on statements made by you in your latest application on file.

Office Use:
Ret. Chp Eff Date:

Policyholder and Participating Organization: **CCPOA Benefit Trust Fund**	Policy No. **G29310**	Date of Retirement:
CCPOA Member's Name (First, Middle Initial, Last)	❑ Male ❑ Female	Date of Birth:

Street:	Phone No.:	Last 4 of SSN:
City:	State:	Zip:

I have joined the CCPOA Retired Chapter and am seeking to rollover my Supplemental Term Life into retirement ❑ _____ (initial here)

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 Dependant Coverage desired.

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

$_____

For Office Use Only_____

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

$_____

Please list spouse benefit amount you are applying for.
The spouse benefit amount must be no greater than
50% of the member's coverage, up to $50,000.

❑ Coverage for dependant child(ren). $750/$7,500 benefit

For Office Use Only_____

If Spouse/Dependant Coverage is being continued, complete the following:

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

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.

"I hereby authorize the CalPERS 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."

Member Signature:	Date:
Spouse Signature (if enrolling):	Date: