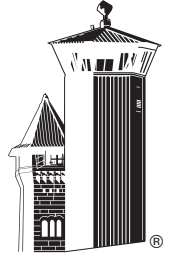


Disability Application Form

1. Fill out application.
2. Sign and Date the form.
3. 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: <input type="checkbox"/> Male <input type="checkbox"/> Female																																															
Address:		City:		State:		ZIP:																																															
Phone:		<table border="1"> <thead> <tr> <th colspan="4">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:</th> </tr> <tr> <th></th> <th>YES</th> <th>NO</th> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>A. The brain, nervous system, epilepsy, Parkinson's disease, stroke, mental or nervous disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>F. The endocrine system including diabetes, thyroid or adrenal disorders?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>B. The respiratory system including tuberculosis, emphysema or COPD?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>G. Cancer, tumor, Hodgkin's disease, leukemia, muscle disorders including Muscular Dystrophy or Multiple Sclerosis?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>C. The heart, heart attack, heart murmur, blood, anemia, high blood pressure, rheumatic fever or vascular disease?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>H. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV or any other immune deficiency disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>D. The gastrointestinal tracts, stomach, gall bladder, liver, hepatitis or pancreas disorders?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>I. Bone Disease or bone injuries including fractures?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>E. The genito-urinary system, kidneys, reproductive organs including prostatitis or uterine fibroids?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>J. Any injury, disease, condition or abnormality not mentioned above?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="3">K. Are you actively working within the duties of your occupation?</td> <td colspan="3"><input type="checkbox"/> <input type="checkbox"/></td> </tr> </tbody> </table>						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, nervous system, epilepsy, Parkinson's disease, stroke, mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	F. The endocrine system including diabetes, thyroid or adrenal disorders?	<input type="checkbox"/>	<input type="checkbox"/>	B. The respiratory system including tuberculosis, emphysema or COPD?	<input type="checkbox"/>	<input type="checkbox"/>	G. Cancer, tumor, Hodgkin's disease, leukemia, muscle disorders including Muscular Dystrophy or Multiple Sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	C. The heart, heart attack, heart murmur, blood, anemia, high blood pressure, rheumatic fever or vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>	H. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV or any other immune deficiency disorder?	<input type="checkbox"/>	<input type="checkbox"/>	D. The gastrointestinal tracts, stomach, gall bladder, liver, hepatitis or pancreas disorders?	<input type="checkbox"/>	<input type="checkbox"/>	I. Bone Disease or bone injuries including fractures?	<input type="checkbox"/>	<input type="checkbox"/>	E. The genito-urinary system, kidneys, reproductive organs including prostatitis or uterine fibroids?	<input type="checkbox"/>	<input type="checkbox"/>	J. Any injury, disease, condition or abnormality not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	K. Are you actively working within the duties of your occupation?			<input type="checkbox"/> <input type="checkbox"/>		
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Institution:		■ Plan Selection at current monthly rate All Rates effective 07/01/2019 <input type="checkbox"/> GOLD SHIELD \$55.00/mo <input type="checkbox"/> New Officer Special Offer \$27.50/mo 1 st 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.		"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."				<h1>ACTIVE</h1> Date of Application:																																															
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.		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. 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.																																																			
Signature of Applicant: X																																																					

We've Got You Covered.

916-779-6300

1-800 In-Unit-6

TAPE TOP CLOSED
DO NOT STAPLE

TAPE TOP CLOSED
DO NOT STAPLE

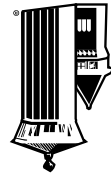
NO TOWERS? NO TRUST



A C C E P T N O S U B S T I T U T E S

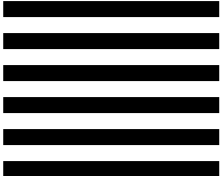


CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-9978



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