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

STL New Officers Only

GROUP SUPPLEMENTAL TERM LIFE INSURANCE

Guarantee Issue Plan

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

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:

Guarantee Issue Supplemental Term Life – Indicate N/A if Dependent Coverage is not desired

Member Name:	☐ Male ☐ Female	Date of Birth:	Benefit Amount: **$125,000**	Monthly Premium: See Price List
Spouse Name:	☐ Male ☐ Female		**$12,500**	See Price List
Children:	☐ Male ☐ Female		☐ 15 days - 6 months of age $750 ☐ 6 months or older $7,500	**$1.40 per family/ per month**
	☐ Male ☐ Female		☐ 15 days - 6 months of age $750 ☐ 6 months or older $7,500	
	☐ Male ☐ Female		☐ 15 days - 6 months of age $750 ☐ 6 months or older $7,500	
	☐ Male ☐ Female		☐ 15 days - 6 months of age $750 ☐ 6 months or older $7,500	
	☐ Male ☐ Female		☐ 15 days - 6 months of age $750 ☐ 6 months or older $7,500	
Hire Date:			**Total Premium:**	

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

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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.

I have read and understand the conditions and exclusions of this group term life insurance plan. I understand that my coverage will be effective the first day of the month immediately following the month for which a payroll deduction is received for the Supplemental Term Life premium, provided that I am actively at work and a CCPOA member on that date. I also understand that the coverage afforded will be guaranteed issue to me based on the statements I have set forth.

NAMING YOUR BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. When naming your beneficiary(ies) please include their full name, address, relationship to you, and if a minor, the age of that minor. If the beneficiary is not related to you either by blood or marriage, insert the words "Not Related." The beneficiary box is on the front of this form. If you need assistance, contact the Trust at 1-800-In-Unit-6.

Following are examples of the most common designations:

- Mary J. Doe, Wife. (not Mrs. John Doe)
- Mary J. Doe, Wife, if living, otherwise to Joe W. Doe, Son.
- Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joe W. Doe, Son, in equal shares, or to the survivor.
- Estate of the Insured.
- If you name more than one beneficiary with unequal share, please show the amount of insurance to be paid to each beneficiary in fractional parts. For example: "1/3 to Mary Jones, Mother, and 2/3 to Edith Jones, Wife".

By signing and dating this application, I and my spouse/domestic partner (if proposed for insurance), request the insurance indicated, understand the effective date criteria, and attest to having read the Fraud Notice indicated above, and to the best of my knowledge and belief, the answers to the questions are true and complete. I understand the principal sum automatically reduces based on the schedule in my Certificate of Insurance and that the premium is payroll deducted.

Member Signature **X**	Date
Spouse Signature (if enrolling) **X**	Date

G-29307-0