STL RETIRING AND HAVE TERM LIFE – USE THIS FORM

GROUP SUPPLEMENTAL TERM LIFE INSURANCE

Retired Rollover Members

Please complete and return this form to the Benefit Trust Fund

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

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.
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:	Email	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 Dependent 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

Is spouse an Active or Retired CCPOA Member? Check box: ☐Yes *or* ☐No
☐ Coverage for dependent child(ren). $750/$7,500 benefit

For Office Use Only_____

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

Full Name of Spouse/Dependent 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: