Don't Lose It. Roll It Over.

NOTICE TO ALL RETIRED (OR ABOUT TO RETIRE) CCPOA MEMBERS:

Many of our Retried Members do not know their standing when it comes to their Life Insurance. Don't let that happen to you.

Here is a brief rundown of your options and available benefits:

STEP ONE: Join

- **You MUST be a member of the CCPOA Retired Chapter to receive ANY benefits through the Trust, including Life.**
- If you are NOT in the retired Chapter - contact the Union to enroll:
  www.ccpoa.org | 1-800-821-6443
- There are some conditions to enrolling if you have let your membership lapse: *Pursuant to Bylaws Article II, Section 4, in order to be eligible as a retired member and receive the benefits of such membership, one must be an uninterrupted member in good standing, except for leaves of absence, from July 1, 2018 until the date their retirement becomes effective or sixty (60) consecutive months prior to their retirement (whichever is shorter).*

STEP TWO: Know what you have now
RETIRED BASIC LIFE

You get some coverage for free.

As a member of the CCPOA Retired Chapter, you are automatically entitled to a $10,000 group life insurance benefit and an automatic $2,000 life insurance benefit for your spouse. Reduces at age 60 to $5,000 member, $1,000 spouse.

There is no underwriting or premium because it is part of your Retired dues. This insurance is provided to all former Active BU6 members who join the Retired Chapter within 90 days of retirement.

If you join after 90 days there is a one year wait for the retired basic group life insurance. This wait does not apply to other retiree programs offered through the Trust.

STEP THREE: Add, Upgrade, Roll-Over

As a CCPOA Member, you have 3 choices:

1. Sign up for coverage, so you have more than just the free basic.
2. Increase your current coverage amount if needed.
3. About to Retire? Roll your current Active coverage over into Retirement.

WHY IT'S WORTH YOUR TIME:

Conversion Privilege

If your coverage is terminated for any reason other than non-payment of premium or cancellation of the group contract, 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).*

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.

Accelerated Death Benefits Options

Potentially relieves some of the financial burdens often 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. *(You should consult a personal tax advisor since proceeds under this benefit may be taxable.)*

Carry Into Retirement

The total amount of coverage an individual may request to rollover under all Group Life Insurance Plans underwritten by New York Life Insurance Company issued to the CCPOA-Benefit Trust Fund may not exceed $250,000 for retired members, $50,000 for their spouses. There is no need for additional underwriting or exams if you select this option. There are reductions in coverage at age 60 and 70. Rates will accordingly adjust. Coverage ends at age 75.

No Cancellation for Ill Health

Once your coverage takes effect, you cannot be cancelled due to a change in your health.

New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010
Under Group Policy Form GMR-ER et al.,
Group Policy Number G29310-0/FACE
NAIC Number 66915

WHAT HAPPENS IF I ALREADY HAVE COVERAGE WHEN I RETIRE?

Currently enrollees in this plan, who become members 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 of insurability, at active rates, by completing the Rollover Request within 60 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 currently limited to a maximum of $50,0 00. Coverage reduces by half at age 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 up to $ 50,000. (Spouse up to $12,500).

Call the Benefit Trust Fund if you have ANY questions about your Life Insurance Coverage.

1-800-In-Unit-6
ccpoabtf.org

Included are the forms you need to manage your Retired Supplemental Term Life:

Ready to Retire and have a current policy?
Fill out the **Retirement ROLLOVER Request** form.

Please call the Trust's Eligibility department to verify your Supplemental Term Life coverage benefit.

Already Retired?
Want to Increase Your Benefit Amount or Add New Coverage?
Fill out the CCPOA **Retired** form.

Not a Retired Chapter member yet?
Go online to **ccpoa.org** and fill out the application.

Return the completed form in the envelope provided:

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

GET THE COVERAGE YOU NEED.

1. **Pick Your Rate.**
2. **Fill out the Application.**
3. **Mail to the Trust.**
4. **Rest Assured.**

Group Retired Supplemental Term Life Rate Chart

Application in back ▶

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	
$100,000	5.25	6.25	7.25	9.25	14.25	22.25	42.25	64.25	102.25	
$125,000	6.50	7.75	9.00	11.50	17.75	27.75	52.75	80.25	127.75	
$150,000	7.75	9.25	10.75	13.75	21.25	33.25	63.25			
$175,000	9.00	10.75	12.50	16.00	24.75	38.75	73.75			
$200,000	10.25	12.25	14.25	18.25	28.25	44.25	84.25			
$225,000	11.50	13.75	16.00	20.50	31.75	49.75	94.75			
$250,000	12.75	15.25	17.75	22.75	35.25	55.25	105.25			

COVERAGE AMOUNT

Rates are based on the attained age of the Insured Person and increase as you enter each new age category. The above premuims apply to Retired CCPOA Members. Rates and/or benefits may be changed on a class basis. An eligible spouse cannot be insured for more than 50% of the member's benefit. If you wish to continue your coverage upon retirement (with some restrictions), you must contact the Benefit Trust Fund office at 1-800 IN UNIT 6. Due to ongoing negoiations, policy features are subject to change.

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	65-69	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	
$37,500	1.75	2.03	2.50	3.63	5.50	7.38	9.25			
$50,000	2.25	2.62	3.25	4.75	7.25	9.75	12.25			

COVERAGE AMOUNT

The premiums shown reflect the current rates (as of January 1, 2019) 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 - 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.]

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, 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 $250,000 for retired members, $50,000 for their spouses.

Numbers show many CCPOA Retired Members do ***NOT*** understand their Life Insurance Benefits.

Learn Your Benefits.

Understand your coverage.

Read this overview.

A SPECIAL MAILING JUST FOR RETIRED (OR ABOUT TO RETIRE) **CCPOA MEMBERS.**

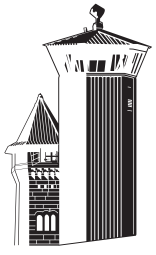
Please make sure you understand your Life Insurance benefits.
Enclosed is an information overview and rate sheets.

If you have any questions about your coverage, contat the Benefit Trust Fund.

<<NAME>>
<<ADDRESS>>
<<CITY>>, <<STATE>> <<ZIP>>

We've Got You Covered.

CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833
1-800-In-Unit-6 | **ccpoabtf.org**



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:

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.

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.

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

STL

ALREADY RETIRED – USE THIS FORM

GROUP SUPPLEMENTAL TERM LIFE INSURANCE

CCPOA Retired Members

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. **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: email:	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 Dependent 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.)

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: 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 dependents, 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