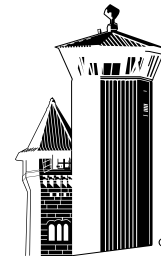


# AD&D Retired Application Form

1. Print-out this form.
2. Fill out application.
3. Sign and Date the form.
4. Mail your application to:

## CCPOA Benefit Trust Fund

2515 Venture Oaks Way, Suite 200  
Sacramento, CA 95833-4235  
[www.ccpoabtf.org](http://www.ccpoabtf.org)



Fold down and seal to return mail

Request for Group Insurance from:	Group Accidental Death And Dismemberment Insurance	Retired
Underwritten by: New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010 Offered through CCPOA Benefit Trust Fund 1-800-468-6486	Mail completed form to: CCPOA Benefit Trust Fund 2515 Venture Oaks Way, Suite 200 Sacramento, CA 95833-4235	
I hereby apply for and authorize CalPERS to deduct from my retirement benefit the necessary deductions for the premium to pay for Accidental Death and Dismemberment insurance under the terms of the Master Policy as follows. I understand that there are benefit reductions at attainment of certain ages. (See the brochure for more information.)		
Full Name (print):	Birthdate:	SSN (Last 4): Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:	City:	State: ZIP:
Phone:	E-mail:	
Beneficiary:	Relationship:	Beneficiary SSN:
Beneficiary Address:	Amount of Principal Sum: See Price List \$	Monthly Premium: See Price List \$
Dependent:	Relationship:	Date of Birth: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent:	Relationship:	Date of Birth: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input checked="" type="checkbox"/> <b>Plan Selection</b> (Check One) <input type="checkbox"/> <b>Member Only</b> <input type="checkbox"/> <b>Family Plan*</b>	<b>Amount of Insurance - Spouse and Children covered <i>only</i> if Family Plan is checked</b>	
* Applicant will be Spouse's and Dependent's beneficiary	<input checked="" type="checkbox"/> <b>Member</b> 100% of Principal Sum	<input checked="" type="checkbox"/> <b>Spouse</b> 50% of Principal Sum (if NO children) 40% of Principal Sum (if children)
		<input checked="" type="checkbox"/> <b>Each Child</b> 10% of Principal Sum (if spouse) 15% of Principal Sum (if NO spouse)
Is spouse an Active or Retired CCPOA Member? Check box: <input type="checkbox"/> Yes or <input type="checkbox"/> No Note: If you are covered as a member, you cannot be covered as a dependent of another member.		
I hereby enroll in the Accidental Death and Dismemberment Program, underwritten by New York Life Insurance and offered through the CCPOA Benefit Trust Fund. I have read and understand the conditions and exclusions of the program. I understand that my coverage will become effective upon the first day of the month following the administrator's receipt of this enrollment form and my first premium payment.		
<b>Fraud Notice</b> – 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.		
By signing and dating this application, I request the insurance indicated, understand the effective date criteria, and attest to having read the Fraud Notice indicated above, and that 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.		
Signature of Applicant: <b>X</b>		Date of Application:
Policy Number: G-29313-0 GMA-GI		9/09ed

# RETIRED

# NO TOWERS? NO TRUST



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

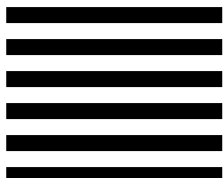


CCPOA Benefit Trust Fund  
2515 Venture Oaks Way, Suite 200  
Sacramento, CA 95833-9978



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**BUSINESS REPLY MAIL**  
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UNITED STATES

