ADD AD&D: Retired Application Form

1. Fill out application.
2. Sign and Date the form.
3. Submit your application to the Trust.

CCPOA Benefit Trust Fund | 2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235 | (916) 779-6300 | **www.ccpoabtf.org**

Request for Group Insurance from:	**Group Accidental Death And Dismemberment Insurance**	**Retired**

Underwritten by: Metropolitan Life Insurance Company I 200 Park Avenue I New York, NY 10166
Offered through CCPOA Benefit Trust Fund (916) 779-6300

Mail completed form to: CCPOA Benefit Trust Fund, 2515 Venture Oaks Way, Suite 200, Sacramento, CA 95833-4235

MEMBER INFORMATION

Full Name (First):	(Middle Initial)	(Last)	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female
Address:			City:	State:	ZIP:
Phone:			Smoker:: ☐ Yes ☐ No	Employee Hire Date:	Occupation or Position:
E-mail:					
Beneficiary:		Relationship:		Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*					

DEPENDENT INFORMATION

Note: If you need to ADD ADDITIONAL DEPENDENTS, please attach another sheet of paper

Dependent:	Relationship:	Date of Birth:	Sex: ☐ Male ☐ Female
Dependent:	Relationship:	Date of Birth:	Sex: ☐ Male ☐ Female
Dependent:	Relationship	Date of Birth:	Sex: ☐ Male ☐ Female

Plan Selection (Check One)

☐ **Member Only** ☐ **Family Plan***

AMOUNT REQUESTED: $_____
See Back for Rate Chart

Amount of Insurance - Spouse and Children covered only if Family Plan is checked

Member	**Spouse**	**Each Child**
100% of Principal Sum	60% of Principal Sum (if NO children) 50% of Principal Sum (if children)w	15% of Principal Sum (if spouse) 20% of Principal Sum (if NO spouse)

Is spouse an Active or Retired CCPOA Member? Check box: ☐ **Yes** or ☐ **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 Metropolitan Life Insurance Company 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.

Fraud Notice – 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.

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:	**Date of Application:**
X	

MetLife

RETIRED

ADD AD&D: Retired Rate Information

COVERAGE AMOUNT:

Amount of Insurance - Spouse and Children covered only if Family Plan is checked		
■ **Member** 100% of Principal Sum	■ **Spouse** 60% of Principal Sum (if NO children) 50% of Principal Sum (if children)	■ **Each Child** 15% of Principal Sum (if spouse) 20% of Principal Sum (if NO spouse)
Rates are based on per $1,000 of coverage. Rates are in $25K increments, up to $1M Max	Member Only: $0.060/$1,000 Family: $0.090/$1,000	

SAMPLE RATE CHART: Monthly Premium

	$25,000	$50,000	$100,000	$500,000	$1,000,000
Member Only	$1.50	$3.00	$6.00	$30.00	$60.00
Family	$2.25	$4.50	$9.00	$45.00	$90.00

You may purchase coverage in any amount up to $1,000,000 in increments of $25,000.
Your premium is deducted monthly.

AD&D MONTHLY PREMIUM		
	Member Only	**Family**
25,000	$1.50	2.25
50,000	$3.00	4.5
75,000	$4.50	6.75
100,000	$6.00	9.00
125,000	$7.50	11.25
150,000	$9.00	13.50
175,000	$10.50	15.75
200,000	$12.00	18.00
225,000	$13.50	20.25
250,000	$15.00	22.50
275,000	$16.50	24.75
300,000	$18.00	27.00
325,000	$19.50	29.25
350,000	$21.00	31.50
375,000	$22.50	33.75
400,000	$24.00	36.00
425,000	$25.50	38.25
450,000	$27.00	40.50
475,000	$28.50	42.75
500,000	$30.00	45.00

AD&D MONTHLY PREMIUM		
	Member Only	**Family**
525,000	$31.50	47.25
550,000	$33.00	49.50
575,000	$34.50	51.75
600,000	$36.00	54.00
625,000	$37.50	56.25
650,000	$39.00	58.50
675,000	$40.50	60.75
700,000	$42.00	63.00
725,000	$43.50	65.25
750,000	$45.00	67.50
775,000	$46.50	69.75
800,000	$48.00	72.00
825,000	$49.50	74.25
850,000	$51.00	76.50
875,000	$52.50	78.75
900,000	$54.00	81.00
925,000	$55.50	83.25
950,000	$57.00	85.50
975,000	$58.50	87.75
1,000,000	$60.00	90.00

D Retired Dental Application Form

1. Fill out application.
2. Sign and Date the form.
3. Submit your application to the Trust.

United Concordia dental®

CCPOA Benefit Trust Fund | 2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235 | (916) 779-6300 | **www.ccpoabtf.org**

1. COVERAGE INFORMATION

Member's Full Name (First, Middle, Last)	Member's SSN	Member's Birth Date

Member's Mailing Address (Street, City, State, ZIP)		
Type of Action: ☐ New Enrollment ☐ Change ☐ Cancellation	Sex: ☐ Male ☐ Female	Member's Daytime Phone #
Name of Dental Plan (For Enrollments or Plan Changes) **CCPOA RETIRED DENTAL PLAN - United Concordia**	Prior State Dental Plan (For Plan Changes Only) **IF YOU ARE CURRENTLY RETIRED AND ENROLLED THROUGH CALPERS, YOU MUST CANCEL YOUR CALPERS DENTAL PLAN TO AVOID DOUBLE BILLING**	

2. SPOUSE OR DOMESTIC PARTNER

Marital Status	Domestic Partnership (Yes/No)	Spouse's or Domestic Partner's SSN
☐ MARRIED ☐ UNMARRIED	☐ YES ☐ NO	

NOTE: YOU MAY BE REQUIRED TO VERIFY DEPENDENTS THROUGH THE ELECTRONIC ENROLLMENT PROCESS.

3. DEPENDENTS

Name	Birth Date	SSN	Relationship

IF MORE DEPENDENTS, ATTACH ADDITIONAL PAGES; ONLY ELIGIBLE, AUTHORIZED DEPENDENTS MAY USE THE PLAN..

■ **Plan Selection** at current monthly rate (Check One) ☐ **Retired Member Only** $38.66 ☐ **Retired Member and One dependent** $82.54 ☐ **Retired Member and Two or more dependents** $141.07	**There is currently no state contribution for this plan. Rates may change, pending any MOU negotiations.**	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. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization.

Fraud Notice – 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**	**Date of Application:**

LP MetLife Legal Plan: Retired Application Form

1. Fill out application.
2. Sign and Date the form.
3. Submit your application to the Trust.

Or fax this form to: 916-779-6355 | Attn: Enrollment

MetLife

CCPOA Benefit Trust Fund | 2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235 | (916) 779-6300 | **www.ccpoabtf.org**

Application **MetLife Retired Legal Plan**

Retired

Underwritten by: Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
Offered through CCPOA Benefit Trust Fund (916) 779-6300

Mail completed form to: CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

MEMBER INFORMATION

Full Name (First):	(Middle Initial)	(Last)	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female
Address:			City:	State:	ZIP:
Phone:			Smoker:: ☐ Yes ☐ No	Employee Hire Date:	Occupation or Position:
E-mail:					

■ **Program Selection** at current monthly rate (Check One)

☐ **MetLife Retired Legal Plan** **$13.99**/mo
Excludes Legal Defense Fund Benefits

Yes, I elect to enroll in MetLife Legal Plans and authorize CalPERS to deduct from my retirement allowance the amount required to cover my share of the cost of enrollment, as it is now of $13.99 per pay period, or as it may be in the future. I understand that this authorization will remain in effect until I cancel it, as long as I remain eligible. I certify I am a retired CCPOA member and that ending my membership will stop all related deductions.

I hereby enroll in the MetLife Retired Legal Program, underwritten by Metropolitan Life Insurance Company 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.

Fraud Notice – 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.

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:	**Date of Application:**
X	

Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

RETIRED

PB Piggyback Dental Retired Application Form

1. Fill out application.
2. Sign and Date the form.
3. Submit your application to the Trust.

CCPOA Benefit Trust Fund | 2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235 | (916) 779-6300 | **www.ccpoabtf.org**

Application **CCPOA Piggyback Dental Program** — Retired

CCPOA Benefit Trust Fund (916) 779-6300

Full Name (Print):	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female
Address:			
City:	State:	ZIP:	Phone:
E-mail:			

List below names and birth dates of spouse and all dependent children under 26 years of age. (Birth dates are required)

Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:y	Family Relationship

Plan Selection at current monthly rate (Check One)

☐ **Retired Member Only** $18.00

☐ **Retired Member and one or more dependents** $34.00

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. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization.

Fraud Notice – 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	**Date of Application:**

Note: If you need to ADD ADDITIONAL DEPENDENTS, please attach another sheet of paper

Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

RETIRED

STL Retired Term Life Application Form

1. Fill out application.
2. Sign and Date the form.
3. Submit your application to the Trust.

MetLife

CCPOA Benefit Trust Fund | 2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235 | (916) 779-6300 | **www.ccpoabtf.org**

ALREADY RETIRED – USE THIS FORM

Request for Group Insurance from:	**Retired Term Life**	**Retired**

Underwritten by: Metropolitan Life Insurance Company I 200 Park Avenue I New York, NY 10166
Offered through CCPOA Benefit Trust Fund (916) 779-6300

Mail completed form to: CCPOA Benefit Trust Fund, 2515 Venture Oaks Way, Suite 200, Sacramento, CA 95833-4235

MEMBER INFORMATION

Full Name (First):	(Middle Initial)	(Last)	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female
Address:			City:	State:	ZIP:
Phone:			Smoker:: ☐ Yes ☐ No	Employee Hire Date:	Occupation or Position:
E-mail:					

BENEFICIARY INFORMATION Note: If you need to ADD ADDITIONAL BENEFICIARIES please attach another sheet of paper

Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			

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 $1,000,000 maximum in $25,000 increments. See rate chart.)

☐ New Coverage ☐ Change in coverage

For Retired CCPOA Member's Spouse

I hereby apply for a **benefit amount** of:

$_____

($12,500 minimum up to $250,000 maximum in increments of $12,500. The spouse benefit amount must be no greater than 50% of the member's coverage.)

☐ Coverage for dependent child(ren). $10,000 benefit

Is spouse an Active or Retired CCPOA Member? Check box: ☐ **Yes** or ☐ **No** Note: If you are covered as a member, you cannot be covered as a dependent of another member.

Continued on back

If Spouse/Dependent Coverage is desired, complete the following:		
Full Name of Spouse/Dependent Children	**Relationship**	**Birth Date**

I hereby enroll in the Retired Term Life Program, underwritten by Metropolitan Life Insurance Company 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.

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.

Fraud Notice – 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.

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). The authorization will remain in effect until canceled by me or by CCPOA. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization.

Signature of Applicant:	**Date of Application:**
X	

Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

RETIRED

STL Retired Term Life: Member Rate Information

CURRENT RETIRED MEMBER INDIVIDUAL MONTHLY PREMIUMS Effective January 1, 2027
Reduces by 50% at age 60, and lesser of 50% or $50K at 70

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59
$25,000	$2.00	$2.00	$2.25	$2.75	$3.50	$5.50	$8.50	$16.25
$50,000	$4.00	$4.00	$4.50	$5.50	$7.00	$11.00	$17.00	$32.50
$75,000	$6.00	$6.00	$6.75	$8.25	$10.50	$16.50	$25.50	$48.75
$100,000	$8.00	$8.00	$9.00	$11.00	$14.00	$22.00	$34.00	$65.00
$125,000	$10.00	$10.00	$11.25	$13.75	$17.50	$27.50	$42.50	$81.25
$150,000	$12.00	$12.00	$13.50	$16.50	$21.00	$33.00	$51.00	$97.50
$175,000	$14.00	$14.00	$15.75	$19.25	$24.50	$38.50	$59.50	$113.75
$200,000	$16.00	$16.00	$18.00	$22.00	$28.00	$44.00	$68.00	$130.00
$225,000	$18.00	$18.00	$20.25	$24.75	$31.50	$49.50	$76.50	$146.25
$250,000	$20.00	$20.00	$22.50	$27.50	$35.00	$55.00	$85.00	$162.50
$275,000	$22.00	$22.00	$24.75	$30.25	$38.50	$60.50	$93.50	$178.75
$300,000	$24.00	$24.00	$27.00	$33.00	$42.00	$66.00	$102.00	$195.00
$325,000	$26.00	$26.00	$29.25	$35.75	$45.50	$71.50	$110.50	$211.25
$350,000	$28.00	$28.00	$31.50	$38.50	$49.00	$77.00	$119.00	$227.50
$375,000	$30.00	$30.00	$33.75	$41.25	$52.50	$82.50	$127.50	$243.75
$400,000	$32.00	$32.00	$36.00	$44.00	$56.00	$88.00	$136.00	$260.00
$425,000	$34.00	$34.00	$38.25	$46.75	$59.50	$93.50	$144.50	$276.25
$450,000	$36.00	$36.00	$40.50	$49.50	$63.00	$99.00	$153.00	$292.50
$475,000	$38.00	$38.00	$42.75	$52.25	$66.50	$104.50	$161.50	$308.75
$500,000	$40.00	$40.00	$45.00	$55.00	$70.00	$110.00	$170.00	$325.00
$525,000	$42.00	$42.00	$47.25	$57.75	$73.50	$115.50	$178.50	$341.25
$550,000	$44.00	$44.00	$49.50	$60.50	$77.00	$121.00	$187.00	$357.50
$575,000	$46.00	$46.00	$51.75	$63.25	$80.50	$126.50	$195.50	$373.75
$600,000	$48.00	$48.00	$54.00	$66.00	$84.00	$132.00	$204.00	$390.00
$625,000	$50.00	$50.00	$56.25	$68.75	$87.50	$137.50	$212.50	$406.25
$650,000	$52.00	$52.00	$58.50	$71.50	$91.00	$143.00	$221.00	$422.50
$675,000	$54.00	$54.00	$60.75	$74.25	$94.50	$148.50	$229.50	$438.75
$700,000	$56.00	$56.00	$63.00	$77.00	$98.00	$154.00	$238.00	$455.00
$725,000	$58.00	$58.00	$65.25	$79.75	$101.50	$159.50	$246.50	$471.25
$750,000	$60.00	$60.00	$67.50	$82.50	$105.00	$165.00	$255.00	$487.50
$775,000	$62.00	$62.00	$69.75	$85.25	$108.50	$170.50	$263.50	$503.75
$800,000	$64.00	$64.00	$72.00	$88.00	$112.00	$176.00	$272.00	$520.00
$825,000	$66.00	$66.00	$74.25	$90.75	$115.50	$181.50	$280.50	$536.25
$850,000	$68.00	$68.00	$76.50	$93.50	$119.00	$187.00	$289.00	$552.50
$875,000	$70.00	$70.00	$78.75	$96.25	$122.50	$192.50	$297.50	$568.75
$900,000	$72.00	$72.00	$81.00	$99.00	$126.00	$198.00	$306.00	$585.00
$925,000	$74.00	$74.00	$83.25	$101.75	$129.50	$203.50	$314.50	$601.25
$950,000	$76.00	$76.00	$85.50	$104.50	$133.00	$209.00	$323.00	$617.50
$975,000	$78.00	$78.00	$87.75	$107.25	$136.50	$214.50	$331.50	$633.75
$1,000,000	$80.00	$80.00	$90.00	$110.00	$140.00	$220.00	$340.00	$650.00

STL Retired Term Life: Member Rate Information

CURRENT RETIRED MEMBER INDIVIDUAL MONTHLY PREMIUMS Effective January 1, 2027 Reduces by 50% at age 60, and lesser of 50% or $50K at 70							
	60-64	65-69	70-74	75-79	80-84	85-89	90+
$25,000	$25.00	$39.75	$60.50	$112.25	$180.00	$295.00	$478.00
$50,000	$50.00	$79.50	$121.00	$224.50	$360.00	$590.00	$956.00
$75,000	$75.00	$119.25					
$100,000	$100.00	$159.00					
$125,000	$125.00	$198.75					
$150,000	$150.00	$238.50					
$175,000	$175.00	$278.25					
$200,000	$200.00	$318.00					
$225,000	$225.00	$357.75					
$250,000	$250.00	$397.50					
$275,000	$275.00	$437.25					
$300,000	$300.00	$477.00					
$325,000	$325.00	$516.75					
$350,000	$350.00	$556.50					
$375,000	$375.00	$596.25					
$400,000	$400.00	$636.00					
$425,000	$425.00	$675.75					
$450,000	$450.00	$715.50					
$475,000	$475.00	$755.25					
$500,000	$500.00	$795.00					

STL Retired Term Life Roll-Over Form

1. Fill out application.
2. Sign and Date the form.
3. Submit your application to the Trust.

MetLife

CCPOA Benefit Trust Fund | 2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235 | (916) 779-6300 | **www.ccpoabtf.org**

RETIRING AND HAVE TERM LIFE – USE THIS FORM

Request for Group Insurance from:	**Retired Term Life Roll-Over**	**Retired**

Underwritten by: Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
Offered through CCPOA Benefit Trust Fund (916) 779-6300

Mail completed form to: CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

MEMBER INFORMATION

Full Name (First):	(Middle Initial)	(Last)	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female
Address:			City:	State:	ZIP:
Phone:			Smoker:: ☐ Yes ☐ No	Employee Hire Date:	Occupation or Position:
E-mail:					

I have joined the CCPOA Retired Chapter and am seeking to rollover my Supplemental Term Life into retirement ☐ _____ **(initial here)**

BENEFICIARY INFORMATION Note: If you need to ADD ADDITIONAL BENEFICIARIES please attach another sheet of paper

Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:
Beneficiary Address: *Applicant will be Spouse's and Dependent's beneficiary*			

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 $1,000,000 maximum in $25,000 increments. See rate chart.)

For Retired CCPOA Member's Spouse
I hereby apply for a **benefit amount** of:

$_____

($12,500 minimum up to $250,000 maximum in increments of $12,500. The spouse benefit amount must be no greater than 50% of the member's coverage.)

☐ Coverage for dependent child(ren). $10,000 benefit

Is spouse an Active or Retired CCPOA Member? Check box: ☐ **Yes** **or** ☐ **No** Note: If you are covered as a member, you cannot be covered as a dependent of another member.

Continued on back

If Spouse/Dependent Coverage is desired, complete the following:		
Full Name of Spouse/Dependent Children	**Relationship**	**Birth Date**

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.

Fraud Notice – 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.

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). The authorization will remain in effect until canceled by me or by CCPOA. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization.

Signature of Applicant:	Date
X	

STL Retired Term Life: Spouse Rate Information

CURRENT RETIRED SPOUSE INDIVIDUAL MONTHLY PREMIUMS Effective January 1, 2027
Spouse benefit reduces by 50% at age 60, and lesser of 50% or $25K at 70

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59
$12,500	$0.88	$0.88	$1.00	$1.25	$1.75	$2.75	$3.75	$4.75
$25,000	$1.75	$1.75	$2.00	$2.50	$3.50	$5.50	$7.50	$9.50
$37,500	$2.63	$2.63	$3.00	$3.75	$5.25	$8.25	$11.25	$14.25
$50,000	$3.50	$3.50	$4.00	$5.00	$7.00	$11.00	$15.00	$19.00
$62,500	$4.38	$4.38	$5.00	$6.25	$8.75	$13.75	$18.75	$23.75
$75,000	$5.25	$5.25	$6.00	$7.50	$10.50	$16.50	$22.50	$28.50
$87,500	$6.13	$6.13	$7.00	$8.75	$12.25	$19.25	$26.25	$33.25
$100,000	$7.00	$7.00	$8.00	$10.00	$14.00	$22.00	$30.00	$38.00
$112,500	$7.88	$7.88	$9.00	$11.25	$15.75	$24.75	$33.75	$42.75
$125,000	$8.75	$8.75	$10.00	$12.50	$17.50	$27.50	$37.50	$47.50
$137,500	$9.63	$9.63	$11.00	$13.75	$19.25	$30.25	$41.25	$52.25
$150,000	$10.50	$10.50	$12.00	$15.00	$21.00	$33.00	$45.00	$57.00
$162,500	$11.38	$11.38	$13.00	$16.25	$22.75	$35.75	$48.75	$61.75
$175,000	$12.25	$12.25	$14.00	$17.50	$24.50	$38.50	$52.50	$66.50
$187,500	$13.13	$13.13	$15.00	$18.75	$26.25	$41.25	$56.25	$71.25
$200,000	$14.00	$14.00	$16.00	$20.00	$28.00	$44.00	$60.00	$76.00
$212,500	$14.88	$14.88	$17.00	$21.25	$29.75	$46.75	$63.75	$80.75
$225,000	$15.75	$15.75	$18.00	$22.50	$31.50	$49.50	$67.50	$85.50
$237,500	$16.62	$16.62	$19.00	$23.75	$33.25	$52.25	$71.25	$90.25
$250,000	$17.50	$17.50	$20.00	$25.00	$35.00	$55.00	$75.00	$95.00

CURRENT RETIRED SPOUSE INDIVIDUAL MONTHLY PREMIUMS Effective January 1, 2027
Spouse benefit reduces by 50% at age 60, and lesser of 50% or $25K at 70

	60-64	65-69	70-74	75-79	80-84	85-90	90+
$12,500	$11.88	$18.75	$30.88	$57.00	$92.62	$149.88	$240.50
$25,000	$23.75	$37.50	$61.75	$114.00	$185.25	$299.75	$481.00
$37,500	$35.62	$56.25					
$50,000	$47.50	$75.00					
$62,500	$59.38	$93.75					
$75,000	$71.25	$112.50					
$87,500	$83.12	$131.25					
$100,000	$95.00	$150.00					
$112,500	$106.88	$168.75					
$125,000	$118.75	$187.50					

Child Benefit/monthly

	Birth up to Age 26
$10,000	$1.65

MetLife

RETIRED

VSP Retired Application Form

1. Fill out application.
2. Sign and Date the form.
3. Submit your application to the Trust.

vsp vision care

CCPOA Benefit Trust Fund | 2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235 | (916) 779-6300 | **www.ccpoabtf.org**

Application **CCPOA Vision Program** — Retired

CCPOA Benefit Trust Fund (916) 779-6300

Full Name (Print):	Birthdate:	SSN (Last 4):	Sex: ☐ Male ☐ Female
Address:			
City:	State:	ZIP	Phone:
E-mail:			

List below names and birth dates of spouse and all dependent children under 26 years of age. (Birth dates are required)

Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship
Dependent Name: First, Middle, Last	Date of Birth:	Family Relationship

■ **Plan Selection** at current monthly rate (Check One)

"ADVANTAGE" OUR FULL SERVICE PLAN		*OR*	"EXAM+" OUR MOST AFFORDABLE	
☐ **Member only**	**$10.58**		☐ **Member only**	**$1.66**
☐ **Member + 1 Dependent**	**$15.31**		☐ **Member + 1 Dependent**	**$2.37**
☐ **Member + Family**	**$27.56**		☐ **Member + Family**	**$4.22**

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. I certify that I am a member of CCPOA and understand that termination of CCPOA membership will cancel all deductions made under this authorization.

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Signature of Applicant:	**Date of Application:**
X	

Note: If you need to ADD ADDITIONAL DEPENDENTS, please attach another sheet of paper

Benefit Trust Fund
COVERING THE MEMBERS OF CCPOA

RETIRED