

# Here are your **Active Member** Applications

**ADD** ACCIDENTAL DEATH & DISMEMBERMENT:  
Active

**GS** GOLD SHIELD:  
Active

**PB** PIGGYBACK:  
Active

**STL** SUPPLEMENTAL TERM LIFE:  
Guarantee Issue  
Active

**APP** BENEFICIARY CHANGE FORM

 CCPOA MEMBERSHIP:  
Active



CCPOA Benefit Trust Fund | (916) 779-6300 | [www.ccpoabtf.org](http://www.ccpoabtf.org)



# AD&D Application Form



1. Fill out application.
2. Sign and Date the form.
3. Mail 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](http://www.ccpoabtf.org)

Request for Group Insurance from:	<b>Group Accidental Death And Dismemberment Insurance</b>			<b>Active</b>		
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				
<b>I hereby apply for and authorize the necessary salary deductions for the premium to pay for Accidental Death and Dismemberment insurance under the terms of the Master Policy as follows:.</b>						
Full Name (print):	Birthdate:	SSN (Last 4):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Address:	City:	State:	ZIP:			
Phone:	E-mail:		Occupation or Position:			
Beneficiary:	Relationship:	Beneficiary SSN:	Beneficiary Occupation:			
Beneficiary Address:		Amount of Principal Sum: See Price List \$	Monthly Premium: See Price List \$			
<b>Note: If you need to ADD ADDITIONAL DEPENDENTS, please attach another sheet of paper</b>						
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			
Dependent:	Relationship:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>Plan Selection</b> (Check One) <input type="checkbox"/> <b>Member Only</b> <input type="checkbox"/> <b>Family Plan*</b> <small>* Applicant will be Spouse's and Dependent's beneficiary</small>		<b>Amount of Insurance - Spouse and Children covered <i>only</i> if Family Plan is checked</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; padding: 5px;"><b>Member</b> 100% of Principal Sum</td> <td style="width: 33%; padding: 5px;"><b>Spouse</b> 60% of Principal Sum (if NO children) 50% of Principal Sum (if children)</td> <td style="width: 33%; padding: 5px;"><b>Each Child</b> 15% of Principal Sum (if spouse) 20% of Principal Sum (if NO spouse)</td> </tr> </table>		<b>Member</b> 100% of Principal Sum	<b>Spouse</b> 60% of Principal Sum (if NO children) 50% of Principal Sum (if children)	<b>Each Child</b> 15% of Principal Sum (if spouse) 20% of Principal Sum (if NO spouse)
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<b>Is spouse an Active or Retired CCPOA Member? Check box:</b> <input type="checkbox"/> <b>Yes</b> <i>or</i> <input type="checkbox"/> <b>No</b> <small>Note: If you are covered as a member, you cannot be covered as a dependent of another member.</small>						
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 – For your protection California law requires the following to appear on this form:</b> 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.						
<b>Signature of Applicant:</b>  <b>X</b>		<b>Date of Application:</b>				
Policy Number: G-29312-0 GMA-GI						



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Application <b>Gold Shield</b> Disability Benefit Plan			Active																																												
Full Name (print):		Birthdate:		SSN (Last 4):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female																																										
Address:		City:		State:	ZIP:																																										
Phone:		<p style="text-align: center;"><b>IN THE PAST 5 YEARS</b> has there existed, or have you been treated for or told by a physician or practitioner that you have conditions implicating any of the following:</p> <table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>A. The brain, nervous system, epilepsy, Parkinson's disease, stroke, mental or nervous disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>F. The endocrine system including diabetes, thyroid or adrenal disorders?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>B. The respiratory system including tuberculosis, emphysema or COPD?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>G. Cancer, tumor, Hodgkin's disease, leukemia, muscle disorders including Muscular Dystrophy or Multiple Sclerosis?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>C. The heart, heart attack, heart murmur, blood, anemia, high blood pressure, rheumatic fever or vascular disease?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>H. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV or any other immune deficiency disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>D. The gastrointestinal tracts, stomach, gall bladder, liver, hepatitis or pancreas disorders?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>I. Bone Disease or bone injuries including fractures?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>E. The genito-urinary system, kidneys, reproductive organs including prostatitis or uterine fibroids?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>J. Any injury, disease, condition or abnormality not mentioned above?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="3">K. Are you actively working within the duties of your occupation?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> </tr> </tbody> </table>					YES	NO		YES	NO	A. The brain, nervous system, epilepsy, Parkinson's disease, stroke, mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	F. The endocrine system including diabetes, thyroid or adrenal disorders?	<input type="checkbox"/>	<input type="checkbox"/>	B. The respiratory system including tuberculosis, emphysema or COPD?	<input type="checkbox"/>	<input type="checkbox"/>	G. Cancer, tumor, Hodgkin's disease, leukemia, muscle disorders including Muscular Dystrophy or Multiple Sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	C. The heart, heart attack, heart murmur, blood, anemia, high blood pressure, rheumatic fever or vascular disease?	<input type="checkbox"/>	<input type="checkbox"/>	H. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV or any other immune deficiency disorder?	<input type="checkbox"/>	<input type="checkbox"/>	D. The gastrointestinal tracts, stomach, gall bladder, liver, hepatitis or pancreas disorders?	<input type="checkbox"/>	<input type="checkbox"/>	I. Bone Disease or bone injuries including fractures?	<input type="checkbox"/>	<input type="checkbox"/>	E. The genito-urinary system, kidneys, reproductive organs including prostatitis or uterine fibroids?	<input type="checkbox"/>	<input type="checkbox"/>	J. Any injury, disease, condition or abnormality not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	K. Are you actively working within the duties of your occupation?			<input type="checkbox"/>	<input type="checkbox"/>	
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Institution:		Watch: <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup>																																													
■ <b>Plan Selection</b> of current monthly rate All Rates effective 07/01/2019 <input type="checkbox"/> <b>GOLD SHIELD</b> \$55.00/mo																																															
<input type="checkbox"/> <b>New Officer Special Offer</b> \$27.50/mo 1 <sup>st</sup> year Gold Shield Date of Graduation: (Must be within 90 days to qualify)		Please explain all of the "YES" answers checked, except "K" (including dates) If necessary, use additional paper. The falsity or lack of completeness of any statement made on this application shall be sufficient reason for the denial, suspension or termination of benefits under this program.																																													
"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). 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."																																															
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AUTHORIZATION: I understand that I will be required to sign a release of medical information provided to me by the Trust Office to determine eligibility for participation in and/or benefits under the Disability Benefit Plan. If my application for participation in the Disability Benefit Program is approved my signature serves as my express written authorization of payroll deductions for the coverage I have elected at the rate in force until I notify the Trust in writing to discontinue deductions, or otherwise cease to be eligible to participate. 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.				<h1>ACTIVE</h1>																																											
Signature of Applicant:  <b>X</b>				Date of Application:																																											

# Piggyback Application Form



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



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Application <b>CCPOA Piggyback Program</b>					Active																																			
<b>CCPOA Benefit Trust Fund 1-800-468-6486</b>																																								
Full Name (Print):	Birthdate:	SSN (Last 4):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female																																					
Address:			<div style="text-align: center; font-weight: bold; font-size: small;">List below names and birth dates of spouse and all dependent children under 26 years of age. (Birth dates are required)</div> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 15%;">First</th> <th style="width: 15%;">Middle</th> <th style="width: 15%;">Last</th> <th style="width: 15%;">Date of Birth</th> <th style="width: 40%;">Family Relationship</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>			First	Middle	Last	Date of Birth	Family Relationship																														
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<input checked="" type="checkbox"/> <b>Plan Selection</b> at current monthly rate (Check One) <input type="checkbox"/> <b>Active Member Only</b> \$16.00 <input type="checkbox"/> <b>Active Member and one or more dependents</b> \$28.00																																								
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<b>Signature of Applicant:</b> <span style="font-size: 2em; font-weight: bold; margin-left: 10px;">X</span>				<b>Date of Application:</b>																																				

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

# Change of Beneficiary Request

## CCPOA Member Information

Member Name		Social Security Number (Last 4)	
Address	City	State / ZIP	
Institution		Home / Cell Phone	

## Primary Beneficiary Name(s): *If more than one beneficiary is listed the total percentage must equal 100%*

Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City	State	Zip Code	
Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City	State	Zip Code	
Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City	State	Zip Code	

## Contingent Beneficiary Name(s): *If more than one beneficiary is listed the total percentage must equal 100%.*

Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City	State	Zip Code	
Name - First	Middle	Last	Birthdate:	%	Social Security Number (Last 4)	
Home or Cell Phone					Relationship to member	
Address (Number and Street)			City	State	Zip Code	

### Please check all boxes this change applies to:

ACTIVE MEMBERS	RETIRED MEMBERS
<input type="checkbox"/> Active Base Life	<input type="checkbox"/> Retired Base Life
<input type="checkbox"/> Supplemental Term Life	<input type="checkbox"/> Retired Term Life
<input type="checkbox"/> AD&D	<input type="checkbox"/> Retired AD&D
<input type="checkbox"/> Accidental Death \$5,000	<input type="checkbox"/> Senior Term Life

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Mail to: CCPOA Benefit Trust Fund

2515 Venture Oaks Way, Suite 200 | Sacramento, CA 95833-4235  
 Phone: 800.468.6486 | 916.779.6300 | Fax: 916.779.6355

