Supplemental Term Life

Applications

STL

For CCPOA Retired Members

Retired Members

- Already Retired - New Coverage Application
- Rollover Existing Coverage Application

retired

CCPOA Benefit Trust Fund | (916) 779-6300 | www.ccpoabtf.org

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: (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: (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.

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.

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.

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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 Members Name (first, Middle Initial, Last)		Date of Birth:	☐ Male ☐ Female
Street:		Phone No.:	Last 4 of SSN:
City:	Email:	State:	Zip:
Proposed Insured's Occupation and Facility:			

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: ☐ YES ☐ NO Spouse: ☐ YES ☐ 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: $______________ Spouse: $______________ Company: ______________ Company: ______________

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.

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

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 cancelled 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.

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

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

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:

Information from **New York Life**

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For Group Supplemental Term Life Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance , we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent 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. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. 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.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing, however, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901 (TTY 866 346-3642). For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: Protected persons[1] have a right of access to certain Confidential abuse information[2] we maintain in our files and they may choose to receive such information directly. You have the right to register as a Protected person by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.

1 Protected person means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.

2 Confidential abuse information means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company

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We've Got You Covered.

(916) 779-6300

1-800-468-6486

CCPOA
Benefit Trust Fund

2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

www.ccpoabtf.org

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