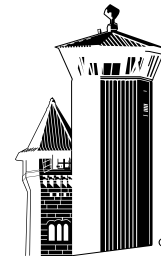


Disability Application Form

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



Fold down and seal to return mail

Application CCPOA 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:	Graduation Date (New Officer Only):		IN THE PAST 5 YEARS 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:																																										
E-mail:			<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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Please explain all of the "YES" answers checked, except "K" (including dates) <i>If necessary, use additional paper.</i> 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.			ACTIVE																																										
<small>"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."</small>				Date of Application:																																									
Signature of Applicant: X																																													

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NO TOWERS? NO TRUST



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

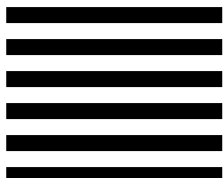


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