

Group Supplemental Term Life Insurance Coverage



Sponsored by the CCPOA Benefit Trust Fund

A Secure Future for Your Family

SUPPLEMENTAL TERM LIFE INSURANCE

SPONSORED BY
CCPOA BENEFIT TRUST FUND

UNDERWRITTEN BY
NEW YORK LIFE
INSURANCE COMPANY



New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010
NAIC Number 66915

Exclusively for Retired Members

- Protection at an affordable rate, including spouses and children
- Limited underwriting
- Same rates for males and females
- A "no cancellation" policy for ill health
- Accelerated death benefits option
- Premiums paid through convenient payroll deductions
- Carryover up to \$250,000 into retirement

This brochure is intended to describe only principle features of the Group Supplemental Term Life Insurance coverage offered through the CCPOA Benefit Trust Fund, and is not a contract. A complete description including features, limitations, exclusions, rates and conditions is contained in the Certificate of Insurance issued to each plan participant. Benefits are provided under the Group Policy GMR – ER et al, Policy Number G29310-0/FACE Issued by New York Life Insurance Company to the CCPOA Benefit Trust Fund.

Effective January 2021 1664646

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Because people depend on you.



Group Supplemental Term Life

It's easy to keep your Term Life Benefits working for you

Looking at retirement options?

Did you know that if you are currently enrolled in the CCPOA Supplemental Term Life program, you can carry-over up to \$250,000¹ of supplemental term life insurance into retirement?

To convert your Supplemental Term Life:

- You must submit a CCPOA Retired Chapter membership application.
- You must notify the Trust 30 days prior to your retirement date that you wish to transfer your supplemental term life insurance.
- Complete and return the Rollover Request form. You have 60 days from the date of your retirement to transfer your term life insurance to the Retired Program.

Rolling over makes sense.

- No underwriting will be necessary if you transfer within the allotted time period.
- Carry your existing benefit amount (up to \$250,000) into retirement.*
- Premiums remain what they were when you were an active officer.

Are you already retired?

Even after retirement, you are eligible to apply for CCPOA Supplemental Term Life using the CCPOA Retired form. Once underwriting is complete, you will have great coverage at great rates²

Included are the forms you need to manage your Retired Supplemental Term Life:

Ready to Retire and have a current policy?

Fill out the **Retirement ROLLOVER Request** form.

Please call the Trust's Eligibility department to verify your Supplemental Term Life coverage benefit.

Already Retired?

Want to increase your benefit amount or add new coverage? Fill out the **CCPOA Retired** form.

Not a Retired Chapter member yet?

Complete the membership application on the back cover.

Detach and return the completed form in the envelope provided, or mail to:

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

¹Members who retire before age 60 may enroll for up to half of the coverage they and their insured spouse had on the date they retired. Member coverage cannot exceed \$250,000 and spouse coverage is limited to a maximum of \$50,000. Coverage reduces by half at ages 60 and by half again at age 70 (maximum 50,000 for member).

² Subject to age limitation as described on the following page. See rate chart.

Commonly Asked Questions

WHAT HAPPENS IF I ALREADY HAVE COVERAGE WHEN I RETIRE?

Currently enrollees in this plan, who become members of the CCPOA Retired Chapter, have the option of moving their coverage and the coverage on their insured spouse into the CCPOA retiree plan without medical evidence of insurability, at active rates, by completing the Rollover Request within 60 days of retirement. Members who retire before age 60* may enroll for up to half of the coverage they and their insured spouse had on the date they retired. Member coverage cannot exceed \$250,000 and spouse coverage is currently limited to a maximum of \$50,000. Coverage reduces by half at age 60 and by half again at age 70 (maximum \$50,000). Premium rates are subject to change.

*Members who retire at ages 60 – 69 may request up to \$125,000. (Spouse up to \$ 25,000).
Members who retire at ages 70 and over may request up to \$ 50,000. (Spouse up to \$12,500).

Who's Eligible To Apply?

As a member of the CCPOA Retired Chapter you can apply for coverage on yourself, your spouse and your dependent children under age 21 years (23, if a full-time student).

If you and your spouse are both retired members of CCPOA, each of you may apply in your own right as a member, not solely as a spouse. If you do so, however, coverage may not be duplicated by applying as dependents of each other and only one of you may request coverage for eligible children.

When Is Coverage Effective?

Your coverage will be effective (subject to approval of your application by the CCPOA Benefit Trust Fund and New York Life), the first (1st) day of the next calendar month immediately following the month for which a deduction from your retirement check is received for the Supplemental Term Life premium, provided you are a member of the CCPOA Retired Chapter on that date.

If you choose to cover your dependents, their insurance will begin on the date you become covered, or the first month following approval of your application to cover a dependent, whichever date is later, provided the required premium is paid.

When Does Coverage End?

Your coverage under this plan will terminate on:

- The date the policy is cancelled; or
- The premium due date on or nearest the date you cease to be a dues paying member of the CCPOA; or
- The premium payment is not made on the due date.

Your dependent's coverage remains in force as long as your coverage remains in effect, premiums are paid when due, and they remain eligible dependents. An eligible spouse cannot be legally separated or divorced from the insured person.

Group Supplemental Term Life

Available through the CCPOA Benefit Trust Fund

This affordable term life insurance program is provided by New York Life. Some of the innovative program features include:

Conversion Privilege

If your coverage is terminated for any reason other than non-payment of premium or cancellation of the group contract, you may convert it to an individual policy customarily offered by New York Life, without providing further proof of your health. Conversion may be requested at any time up to 31 days after termination of your original coverage. This conversion privilege is also available to your insured spouse and/or children should you pass away. (See your Certificate of Insurance for more information).

30-Day “Free Look”

You have 30 days to look over your new insurance program and discuss it with your family and advisors. If for any reason you're not satisfied, you may return your certificate within 30 days of your effective date of coverage for a full refund, minus any claims paid.

Accelerated Death Benefits Options

Potentially relieves some of the financial burdens often associated with a terminal illness by allowing you (and your spouse, if covered) a one-time option to receive up to 50% of the term life insurance proceeds, to a maximum of \$100,000, upon being diagnosed by a physician as having less than 12 months to live.

(You should consult a personal tax advisor since proceeds under this benefit may be taxable.)

Carry Into Retirement

The total amount of coverage an individual may request to rollover under all Group Life Insurance Plans underwritten by New York Life Insurance Company issued to the CCPOA-Benefit Trust Fund may not exceed \$250,000 for retired members, \$50,000 for their spouses. There is no need for additional underwriting or exams if you select this option. There are reductions in coverage at age 60 and 70. Rates will accordingly adjust. Coverage ends at age 75.

No Cancellation for Ill Health

Once your coverage takes effect, you cannot be cancelled due to a change in your health.



New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010
Under Group Policy Form GMR-ER et al.,
Group Policy Number G29310-0/FACE
NAIC Number 66915

IMPORTANT NOTE: This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by New York Life Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder. This program may vary and may not be available to residents of all states.

How Much Do You Need?

There is no magic formula to determine how much life insurance you should have. However, many financial advisors say that you need 5-6 times your annual income in life insurance.

There are a number of factors that should be considered when estimating how much life insurance you should carry, including final expenses, re-education or retirement funds for surviving spouse, supplemental income to maintain mortgage payments, and other expenses.

Why You Need Life Insurance

- If you have people who depend on you or your income, you need life insurance.
- Life insurance helps plan for your dependents' future financial needs, even if you're not around.
- You get homeowners insurance to protect your home. Why wouldn't you get life insurance to protect your family?
- Life insurance benefits can:
 - Help pay off your mortgage or other family debts
 - Help cover ongoing daily expenses and bills once you're gone
- If you still have family members depending on you to provide for them, having life insurance can be critical.

Which forms do you need to manage your Retired Supplemental Term Life?

Ready to Retire and Already Have Coverage?

Fill out the **Retirement ROLLOVER Request** form.

Already Retired?

Want to increase your benefit amount or add new coverage?

Fill out the **CCPOA Retired** form.

Return the completed form in the envelope provided.

Highlights

- Protection at an affordable cost, including spouses and children
- Limited underwriting
- Same rates for males and females
- A "no cancellation" policy for ill health
- Accelerated Death Benefit option
- Carryover up to \$250,000 into retirement

INFORMATION ABOUT CHOOSING A MINOR BENEFICIARY.

If at the insured's death, the named beneficiary of this insurance is a minor, the laws of most states require that a parent or guardian of the minor's estate be appointed to receive the proceeds for the minor. Of course, the legal requirements of each state differ, and in some cases, New York Life may be permitted to pay nominal amounts directly to the minor beneficiary; but, as a general rule, we will require the appointment of a guardian in these situations.

We are giving you this information so that you will be aware of the delay in claims payment which may result from the need to have a guardian appointed.

If you have any question about the propriety of naming a minor as beneficiary of this insurance, you should consult your legal counsel.

Group Retired Supplemental Term Life Rate Chart

Application in back ►

CURRENT MEMBER INDIVIDUAL MONTHLY PREMIUMS - Group Supplemental Term Life Insurance										Effective January 1, 2021
AGE	< 30	30-34	35-39	40-44	< 45-49	50-54	55-59	60-64	65-69	70-74
\$25,000	1.71	2.00	2.28	2.85	4.28	6.56	12.26	18.53	29.36	44.46
\$50,000	3.14	3.71	4.28	5.42	8.27	12.83	24.23	36.77	58.43	88.64
\$75,000	4.56	5.42	6.27	7.98	12.26	19.10	36.20	55.01	87.50	-
\$100,000	5.99	7.13	8.27	10.55	16.25	25.37	48.17	73.25	116.57	-
\$125,000	7.41	8.84	10.26	13.11	20.24	31.64	60.14	91.49	145.64	-
\$150,000	8.84	10.55	12.26	15.68	24.23	37.91	72.11	-	-	-
\$175,000	10.26	12.26	14.25	18.24	28.22	44.18	84.08	-	-	-
\$200,000	11.69	13.97	16.25	20.81	32.21	50.45	96.05	-	-	-
\$225,000	13.11	15.68	18.24	23.37	36.20	56.72	108.02	-	-	-
\$250,000	14.54	17.39	20.24	25.94	40.19	62.99	119.99	-	-	-
COVERAGE AMOUNT	Rates are based on the attained age of the Insured Person and increase as you enter each new age category. The above premiums apply to Retired CCPOA Members. Rates and/or benefits may be changed on a class basis. An eligible spouse cannot be insured for more than 50% of the member's benefit. If you wish to continue your coverage upon retirement (with some restrictions), you must contact the Benefit Trust Fund office at 1-800 IN UNIT 6. Due to ongoing negotiations, policy features are subject to change.									

CURRENT SPOUSE INDIVIDUAL MONTHLY PREMIUMS - Group Supplemental Term Life Insurance										Effective January 1, 2021
AGE	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
\$12,500	0.86	0.96	1.14	1.57	2.28	3.00	3.71	8.98	13.97	22.80
\$25,000	1.43	1.64	2.00	2.85	4.28	5.70	7.13	17.67	27.65	-
\$37,500	2.00	2.31	2.85	4.14	6.27	8.41	10.55	-	-	-
\$50,000	2.57	2.99	3.71	5.42	8.27	11.12	13.97	-	-	-
COVERAGE AMOUNT	The premiums shown reflect the current rates (as of January 1, 2021) and benefit structure. Premiums may be changed by New York Life on any premium due date, but not more than once in any 12-month period, and on any date on which benefits are changed. Your rate may change only if they are changed for all others in the same class of insureds under this group policy. For example, a class of insureds is a group of people with all the same issue age and gender. Premiums shown are payroll deducted and will increase on the premium due date coinciding with or next following the date that a member or spouse enters a new age bracket. Benefit option amounts are subject to change by agreement between New York Life and the Trustees.									

Dependent CHILDREN MONTHLY PREMIUMS - Group Supplemental Term Life Insurance	
\$7,500	\$1.65 / per family Benefit Amount per child age 6 months – 21, or 23 if full time student. [\$750 for children from 15 days old to 6 months.]

Note: If you are covered as a member, you cannot be covered as a dependent of another member.

EXCLUSION: Suicide is excluded from coverage for the first two years, whether sane or insane. If a covered person does commit suicide within the first two years, New York Life will only pay an amount equal to the premium paid for coverage till the date of death. The Life Insurance Benefit is payable if a member is covered under the policy and commits suicide after the two year period.

The total amount of coverage an individual may request under all Group Life Insurance Plans underwritten by New York Life Insurance Company issued to the CCPOA Benefit Trust Fund may not exceed \$250,000 for retired members, \$50,000 for their spouses.

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 persons¹ have a right of access to certain Confidential abuse information² 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
8.12 ed.



New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010

**Not a member of the Retired Chapter of the
California Correctional Peace Officers Association?**

It's Not Too Late!

Sign Up Today!



You can now sign-up online directly at CCPOA

Go to: **ccpoa.org/members/**

Or contact CCPOA by phone:

Sacramento Office	Fresno Office	Rancho Cucamonga Office
1-800-821-6443	1-800-832-1415	1-800-221-7397

*Remember - You must enroll within 90 days of retirement from CCPOA
or there will be a one (1) year waiting period for membership life insurance to be effective.*

If you have any questions regarding other benefits available to Retired members,
please contact the Trust.

We've Got You Covered.

1-800-In-Unit-6

1-800-468-6486

NOTICE: Pursuant to Bylaws Article II, Section 4, in order to be eligible as a retired member and receive the benefits of such membership, one must be an uninterrupted member in good standing, except for leaves of absence, from July 1, 2018 until the date their retirement becomes effective or sixty (60) consecutive months prior to their retirement (whichever is shorter).



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:	<input type="checkbox"/> Male <input type="checkbox"/> 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: \$ _____ <i>(\$25,000 minimum up to \$250,000 maximum in \$25,000 increments. See rate chart.)</i> <input type="checkbox"/> New Coverage <input type="checkbox"/> Change in coverage IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT TOTAL AMOUNT DESIRED			For Retired CCPOA Member's Spouse I hereby apply for a benefit amount of: \$ _____ <i>(\$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.)</i> Is spouse an Active or Retired CCPOA Member? Check box: <input type="checkbox"/> Yes or <input type="checkbox"/> No <input type="checkbox"/> Coverage for dependent child(ren). \$750/\$7,500 benefit IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT TOTAL AMOUNT DESIRED				
For Office Use Only _____			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	
A	Are you taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?			YES	NO	YES	NO
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?						
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C	During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs?						
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: <input type="checkbox"/> YES <input type="checkbox"/> NO Spouse: <input type="checkbox"/> YES <input type="checkbox"/> 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 – 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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.



RETIRING AND HAVE TERM LIFE – USE THIS FORM



GROUP SUPPLEMENTAL TERM LIFE INSURANCE Retired Rollover Members

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

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue, New York, NY, 10010

Please complete and return this form to the Benefit Trust Fund

Please Print Use Dark Ink Do Not Erase Initial All Changes.		Office Use:
To continue coverage New York Life will rely on statements made by you in your latest application on file.		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)			<input type="checkbox"/> Male <input type="checkbox"/> 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.

<p>For Retired CCPOA Member I hereby apply for a benefit amount of:</p> <p>\$ _____</p> <p>For Office Use Only _____</p>	<p>For Retired CCPOA Member's Spouse I hereby apply for a benefit amount of:</p> <p>\$ _____</p> <p><i>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</i></p> <p>Is spouse an Active or Retired CCPOA Member? Check box: <input type="checkbox"/> Yes or <input type="checkbox"/> No</p> <p><input type="checkbox"/> Coverage for dependent child(ren). \$750/\$7,500 benefit</p> <p>For Office Use Only _____</p>
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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:

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.

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.