Peace Officers Research Association *of California*
Insurance & Benefits Trust

ASSOCIATION APPLICATION FOR PARTICIPATION

Name of Association: _____

Mailing Address: _____

Authorized Representative: _____

Phone: 1)_____ 2)_____ e-mail: _____

Alternate Authorized Representative: _____

Phone: 1)_____ 2)_____ e-mail: _____

Total Members in Association: _____,

Does Association cover PMA, Y / N , Number _____, Ranks _____

Does Association cover Non-Sworn, Y / N, Number _____, job classifications _____

Does Association cover Part-time, Seasonal or volunteer worker, Y / N , Number _____, Type _____

Circle the benefit(s) your Association is interested in participating in:

Long Term Disability CalPERS Health AFLAC Term Life California Casualty Auto/Home

If Health, what dollar or percentage of premium does the employee pay towards coverage _____

Regarding health, what is most important to your group, Control Cost Y / N , Richer Benefits Y / N ,

The Undersigned understands that the Insurance and Benefits Trust of PORAC (the "Trust") limits the number of Non-Sworn covered under the health plan to not more than 20% of the total Association's membership.

If Long Term Disability, does the Association currently have coverage, Y / N, Name of carrier _____

The Undersigned acknowledges that I have the authority to execute this document on behalf of the above described Association (the "Association"). I further acknowledge that any benefits approved are conditioned on the Association's continuing membership in good standing with PORAC and that this requirement has been communicated to the Association's members. I understand that if the Association withdraws from PORAC, all Trust benefits for the Association's members will be terminated. Lastly, I acknowledge that I have read and understand the Trust's Benefit Eligibility Policy and this form, that the information provided in this application is true and correct, that the contents of this form are binding on the Association and any successors thereto, and that the Trust will rely on the information.

Signature of Authorized Representative: _____

Name: _____ Title: _____ Date: _____

Please return application, a list of Association members who will participate in the Trust's programs along with their home and email addresses to: Insurance and Benefits Trust of PORAC
4010 Truxel Rd, Sacramento, CA 95834