

# Application for Individual Life Insurance with the UNITED STATES LETTER CARRIERS MUTUAL BENEFIT ASSOCIATION (MBA)

Home Office: 100 Indiana Avenue N.W., Washington, DC 20001, Phone (202)638-4318  
Executive Office: Nashville, TN

A Fraternal Benefit Society

LICC

**1. Type of Insurance (please, circle one Insurance type)**

**Note: A separate application must be completed for each Insurance type selected.**

- |   |   |
|---|---|
| Independence (Single Premium Whole Life Plan)<br>20 Pay Whole Life Plan<br>Paid Up at Age 65 Whole Life Plan<br>Whole Life Plan | 10 Year Renewable and Convertible Term Plan<br>5 Year Renewable and Convertible Term Plan<br>20 Year Term<br>Term to Age 65 |
|---|---|

Coverage Information	\$10,000	\$25,000	\$50,000	\$100,000	Other (Specify)
Member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

**2. NALC Member's Information: (Please print or type)**

**Social Security No.** \_\_\_\_\_

Name \_\_\_\_\_  
(First) (Middle Initial) (Last)

**NALC Branch No.** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

**Member's Sex:**  M  F

State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Date of Birth**

Telephone No. (\_\_\_\_\_) \_\_\_\_\_  
Area Code

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Mo/Day/Yr)

**3. Spouse Information:**

Name \_\_\_\_\_  
(First) (Middle Initial) (Last)

**Sex:**  M  F

Social Security No. \_\_\_\_\_

Date of Birth \_\_\_\_\_  
(Mo/Day/Yr)

**4. Children Information: (Only complete, if you are applying for child or children coverage)**

Name	Sex	Date of Birth <small>(Mo/Day/Yr)</small>	Social Security No.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**5. Payroll Deduction:** I hereby authorize the U.S. Postal Service: (1) to deduct from my salary or wages such amounts as may be required by the United States Letter Carriers Mutual Benefit Association (MBA) to pay premiums due from me for insurance; and (2) to pay the amounts thereof on my behalf to the MBA. The authorization shall continue during my employment in any capacity by the U.S. Postal Service or until canceled by me by written notice to the MBA. Note: You do authorize deduction of your premium, unless you check a box below. Payroll deductions will start approximately 28 days after the receipt of your application.

I do not want to use payroll deduction (check one):  Bill me monthly  Bill me annually

**6A. Health:** Has any proposed insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:

	Proposed Insured (s):					
	Member		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. High blood pressure, coronary artery disease, heart attack, stroke, other heart disease or disorders of the circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Emphysema or chronic respiratory disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Hepatitis or other diseases of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Blood disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Diabetes that require insulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Within the past five (5) years been advised to have any diagnostic test (except those related to the Human Immunodeficiency Virus (AIDS virus)), hospitalization or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(OVER)



6B. Please list any current medications: \_\_\_\_\_  
 \_\_\_\_\_

6C. Proposed insured height \_\_\_\_\_ and weight \_\_\_\_\_

**Proposed Insured (s):**  

<u>Member</u>		<u>Spouse</u>		<u>Child(ren)</u>	
Yes	No	Yes	No	Yes	No

6D. Within the past five (5) years, has any of the proposed insured been:  
 Disabled or claimed disability?

6E. For any question 6A or 6D above which has a YES response, please **explain** fully below:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If you need additional space, use a separate page.

7. **Ownership:** The NALC member will be the policy owner unless otherwise specified below.  
**The owner must be in accordance with the provisions in the USLCMBA Constitution General Laws – LAW 1.**

Name \_\_\_\_\_  
(First) (Middle Initial) (Last)

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

8. **Beneficiary:** The beneficiary named below of this policy application will receive the proceeds when the insured dies:

Name	Address	Relationship	Social Security No.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you need additional space, please list on a separate sheet of paper.

9. **Dividends:** MBA will use the Paid-Up Additions Option, unless you inform the MBA otherwise. (Note that the Term Life policies will use the dividends on deposit option if dividends are paid).

10. **Effective Date:** Insurance applied for in this policy application will become effective on the date the MBA receives the first premium payment, provided the MBA approves this application and issues a policy of insurance. If MBA does not approve this application, the full premium payment will be returned. **No insurance shall become effective under any policy herein applied for unless the Proposed Insured(s) is (are) alive and in sound health on the policy's effective date.**

11. **Replacement:** Do any proposed insureds have existing life insurance or annuity contracts? Yes  No   
 Is this policy intended to replace or change any existing life insurance or annuity policy(ies)? Yes  No

If yes, please indicate below

Name of Life Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Address \_\_\_\_\_

12. **Declaration:** I (We) have **read** this application for insurance. I (We) **understand** that the MBA will base its decision whether to issue a policy on these answers I (We) have given in this application. I (We) **represent** that all statements and answers made in this application, which includes any explanations on accompanying pages, are true and complete to the best of my (our) knowledge and belief.

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

\_\_\_\_\_  
 Signature of NALC Member Date

\_\_\_\_\_  
 Signature of Spouse, if proposed for insurance Date

\_\_\_\_\_  
 Signature of any child age 18 or over, if proposed for insurance Date

\_\_\_\_\_  
 Signature of Parent or Guardian of child under 18 years of age Date  
 If proposed for insurance  Father  Mother  Legal Guardian