

# Application for 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*

**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)**

**10 Year Renewable and Convertible Term Plan**

**20 Pay Whole Life Plan**

**Paid Up at Age 65 Whole Life Plan**

**Paid Up at Age 90 Whole Life Plan**

**Universal Life Plan**

<u>Coverage Information</u>	<u>\$10,000</u>	<u>\$25,000</u>	<u>\$50,000</u>	<u>\$100,000</u>	<u>Other (Specify)</u>
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)**

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

**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 of the Proposed Insured been told by a healthcare professional that he or she has or had:

	<b>Proposed Insured(s):</b>					
	<u>Member</u>		<u>Spouse</u>		<u>Child(ren)</u>	
	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 kidney?	<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"/>

**Proposed Insured(s):**  

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

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?  Yes  No  Yes  No  Yes  No
8. Within the past five (5) years been advised to have any Diagnostic test, hospitalization or surgery?  Yes  No  Yes  No  Yes  No

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. Has any of the proposed Insured been: Disabled or claimed disability?  Yes  No  Yes  No  Yes  No

6E. For any question 6A or 6D above to which you responded YES, please **explain** fully below:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If you need additional space, use a separate page.

7. **Ownership:** Unless you tell the MBA otherwise, the NALC member will be the owner of each policy.
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 (Option C), unless you inform the MBA otherwise (with the exception of, the 10-year Renewable and Convertible Term Life policies. The MBA will use dividends on deposit).
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:** Is this policy or (are these policies) intended to replace or change any life insurance or annuity(ies) policy(ies) that you presently own? 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.

**It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**

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