# 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**

| Coverage Information | $10,000 | $25,000 | $50,000 | $100,000 | Other *(Specify)* |
|---|---|---|---|---|---|
| Member | ❑ | ❑ | ❑ | ❑ | ❑_____ |
| Spouse | ❑ | ❑ | ❑ | ❑ | ❑_____ |
| Child | ❑ | ❑ | ❑ | ❑ | ❑_____ |

**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 _____ **Sex: ❑ M ❑ F**
(First) (Middle Initial) (Last)

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 (Mo/Day/Yr) | 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 of the Proposed Insured been told by a healthcare professional that he or she has or had:

| | Proposed Insured(s): Member Yes | Member No | Spouse Yes | Spouse No | Child(ren) Yes | Child(ren) No |
|---|---|---|---|---|---|---|
| 1. High blood pressure, coronary artery disease, heart attack, stroke, other heart disease or disorders of the circulatory system? | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 2. Emphysema or chronic respiratory disease? | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 3. Hepatitis or other diseases of the kidney? | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 4. Blood disease or disorder? | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 5. Cancer? | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 6. Diabetes that require insulin? | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

(OVER)

| | Proposed Insured(s): Member Yes | Member No | Spouse Yes | Spouse No | Child(ren) Yes | Child(ren) 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? | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 8. Within the past five (5) years been advised to have any Diagnostic test, hospitalization or surgery? | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

**6B.** Please list any current medications: _____

_____

**6C.** Proposed Insured height _____ and weight _____

| | Proposed Insured(s): Member Yes | Member No | Spouse Yes | Spouse No | Child(ren) Yes | Child(ren) No |
|---|---|---|---|---|---|---|
| **6D.** Has any of the proposed Insured been: Disabled or claimed disability? | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

**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.

***WARNING: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.***

_____ _____
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