

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)

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

	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 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"/>

(OVER)

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.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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