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: Within the past 5 years has any Proposed Insured been treated for or been diagnosed by a health care professional as having:

	Proposed Insured(s):					
	Member		**Spouse**		**Child(ren)**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
1. High blood pressure?	❑	❑	❑	❑	❑	❑
2. Chronic respiratory disease?	❑	❑	❑	❑	❑	❑
3. Diseases of the kidney?	❑	❑	❑	❑	❑	❑
4. Blood disease or disorder?	❑	❑	❑	❑	❑	❑
5. Within the past five (5) years been advised to have any diagnostic test, hospitalization or surgery?	❑	❑	❑	❑	❑	❑

Has any Proposed Insured been treated for or been diagnosed by a health care professional as having:

6. Coronary artery disease, heart attack, stroke, other heart disease or disorders of the circulatory system?	❑	❑	❑	❑	❑	❑

	Proposed Insured(s): Member Yes	Member No	Spouse Yes	Spouse No	Child(ren) Yes	Child(ren) No
7. Emphysema?	❑	❑	❑	❑	❑	❑
8. Hepatitis?	❑	❑	❑	❑	❑	❑
9. Cancer?	❑	❑	❑	❑	❑	❑
10. Diabetes that require insulin?	❑	❑	❑	❑	❑	❑
11. You need not disclose an HIV (AIDS virus) test which was administered: (1) to a criminal offender or criminal victim as a result of a crime that was reported to the police; (2) to a patient who received the services for emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services.	❑	❑	❑	❑	❑	❑

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.

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

_____ _____
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