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>Co</u>	<u>verage</u>	Intormation	<u>\$10,000</u>	<u>\$25,000</u>	<u>\$50,000</u>	<u>\$100,000</u>		<u>Oti</u>	ner_(S	specit	<u>V)</u>	
	Me	mber						_ _				
	Spo	ouse						\Box _				
	Chi	ld						_ _				
2.	NALC I	Wember's Info		Social Security No.								
	Name _											
	A	(First)	(Middle	,	(Last)			NALC	Bran	ch No	•	
										.		
2.	City						Member's Sex: ☐ M ☐ F					
	State _			de			th					
	Telepho	one No.(ode)					//	/_ //Day/Y	r)		
3.	Spouse	e Information:										
2. 4. 5.	Name _						Se	x : [⊐м	□F		
		(First)	(Mido	dle Initial)	(Last)							
	Social S	Security No				Date of Birth		//	Vr\	_		
	Ola II alaa		· (O. d	: :	la deserviciones de Malacones			пограуг	11)			
4.	Childre	n intormation: Na		, if you are app	lying for child or o	cnlidren cover ate of Birth	age)	Soci	al Sad	curity	No.	
		INa	ille			(Mo/Day/Yr)		3001	ai Set	urity	NO.	
5.	Payroll	Deduction: I h	nereby authorize	the U.S. Postal	Service: (1) to de	educt from my	salary o	or wage	es suc	h amo	unts as	
	may be	required by the	e United States I	Letter Carriers I	Mutual Benefit As	ssociation (ME	BA) to pa	ay prer	miums	due fi	rom me	
		. ,			ny behalf to the Me or until canceled						•	
	do auth	orize deduction	of your premiur	n, unless you cl	heck a box below							
	days af	ter the receipt o	of your application	n.								
	I do not	want to use pa	yroll deduction ((check one):	☐ Bill me mo	onthly	☐ Bill	me ar	nnually	/		
6A	. Hea	alth: Has anv o	f the Proposed I	nsured been tol	d by a healthcare	e professional	that he	or she	has o	or had:		
		, , , , , , , , , , , , , , , , , , , ,								ed(s):		
							ember •	<u>Spo</u>	<u>use</u>	Chilo	d(ren)	
	1.	High blood pre	essure, coronary	artery disease.	heart attack, stro	Ye : oke.	s No	Yes	No	Yes	No	
		•		ase or disorders of the circulator								
	2.	Emphysema o	r chronic respira	tory disease?								
	3.	Hepatitis or oth	her diseases of t	he kidney?								
	4.	Blood disease	or disorder?									
	5.	Cancer?										
	6.		require insulin?									
	٥.	a.5000 that i	- qu			_	_	_	_	_	_	

LIFE APP 2012 WI

Member Spouse Children Yes No Yes			•						Proposed Insured(s):						
7. Have you been diagnosed with or treated by a member of the medical profession for Aquired immune Deficiency Syndrome (AIDS), AIDS. Related Complex (ARC), or any other immune deficiency (AIDS), AIDS. Related Complex (ARC), or any other immune deficiency (INIX) (HIV)? 8. Within the past five (6) years been advised to have any Diagnostic test, hospitalization or surgery? 66. Proposed Insured height															
profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder excluding Human Immunodeficiency Virus (HIV)? 8. Within the past five (5) years been advised to have any Diagnostic test, hospitalization or surgery? Bell Please list any current medications: 6C. Proposed Insured height and weight		7							No	Yes	Yes No				
Related Complex (ARC), or any other immuned efficiency (Virus (HIV)? 8. Within the past five (6) years been advised to have any Diagnostic test, hospitalization or surgery? 6B. Please list any current medications: 6C. Proposed Insured height		7.													
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Proposed Insured height		8.	. Within the past five	e (5) vears bee	en advised to have	e anv									
Address Relationship Social Security No. Proposed Insured height Proposed Insured (s); Member Spouse Children) Proposed Insured (s); Proposed Insured Insured Insured (s); Proposed Insured (s); Proposed Insured Insured Insured (s); Proposed Insur		0.				o uny									
### Proposed Insured(s): Member Spouse Child(tren) Member Member	6B.	Р	lease list any current	medications:											
### Proposed Insured(s): Member		_													
6D. Has any of the proposed Insured been: Disabled or claimed disability?	6C.	Р	roposed Insured heig	ht	and weight	<u> </u>			Proi	nosed	Insur	ed(s).			
See No Yes No Yes No Yes No Yes No Dec. No Dec								Men	-						
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.															
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. 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 no 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) allive and in sound health on the policy 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? Name of Life Insurance Company Yes No If yes, please indicate below: Name of Life Insurance Company Yes No Policy No. Address 12. Declaration: I (We) have read this application for insurance. I (We) understand that the MBA will base its decisic whether to issue a policy on these answers I (We) have given in this application. I (We) represent that all statemen and answers made in this application, which includes any explanations on accompanying pages, are true and complet to the best of my (our) knowledge and belief. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submin an application or files a claim containing a false or deceptive statement may have violated state law. Signature of spouse, if proposed for insurance Signature of any child age 18 or over, if proposed for insurance Da	6D.	Н	as any of the propose	ed Insured bee	en: Disabled or cla	aimed disabili	ty?								
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LIFE APP 2012 WI (Rev. 09/12)