APPLICATION

1. Enrollments Desired (check one): ❑ Member Only ❑ Member and All Children ❑ Member and Spouse ❑ Member, Spouse and All Children

2. Benefit Desired (check one): ❑ $100 Per Day ❑ $75 Per Day ❑ $50 Per Day ❑ $30 Per Day

3. NALC Member's Name ______________________ NALC Branch No. ____________

   Social Security No. ______________________ Sex: ❑ Male ❑ Female Date of Birth: Mo. / Day / Yr.

4. Home Address ______________________________________
   Street City State Zip Code

   Telephone No. ______________________________________

5. Information on Family Members Proposed for Insurance:

	First Name	Sex (M or F)	Social Security Number	Date of Birth (Mo. Day. Yr.)
Spouse				
Child				
Child				
Child				
Child				

6. **Payroll Deduction:** I hereby authorize the U.S. Postal Service (1) to deduct each pay period from my salary or wages such amounts as may be required by the U.S. Letter Carriers Mutual Benefit Association to pay premiums due from me for insurance and (2) to pay the amounts thereof on my behalf to the USLCMBA. The authorization shall continue during my employment in any capacity by the U.S. Postal Service until canceled by me by written notice to the USLCMBA.

   Note: By signing below, you authorize deduction of your premium unless you check a box below. Payroll deductions start approximately 28 days after receipt of your application.

   I do not want to use payroll deduction (check one): ❑ Bill me monthly ❑ Bill me annually

   Retirees: You may choose to pay your premiums monthly or annually.
   Please check one: ❑ Bill me monthly ❑ Bill me annually
   Sorry, payroll deduction cannot be used by retirees.

7. **Effective Date:** Your plan will be effective on the date the first premium for the plan is deducted from member's pay.

   I understand and agree that this application as completed and signed will form the basis of the policy issued and that this policy is not intended to replace or change any insurance policy I presently own.

   I understand and agree that any sickness or disease which any person covered by this policy had during the twelve months prior to the effective date of this coverage will not be covered until twelve consecutive months have passed without medical advice or treatment for such condition, or until this coverage has been in force for one year, whichever occurs first. If benefits are claimed under the policy issued, I authorize physicians and medical institutions to furnish the U.S. Letter Carriers Mutual Benefit Association with information regarding medical history, physical condition and diagnosis of the insureds.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

I hereby attest that I am purchasing this policy as a supplement to my health coverage, which meets the federal requirments of minimum essential coverage.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Do Not Write Below

USPS Finance Number ____________

St. Code ____________

Signature of Member ______________________ Date ____________

MS Form 575 (Rev 9/14)