## **Application for Individual 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

	verage	<u>Information</u>	<u>\$10,000</u>	<u>\$25,000</u>	<u>\$50,000</u>	<u>\$100,000</u>	<u>Ot</u>	<u>her (Specify)</u>		
	Member	's Parent								
	(The Pro	posed Insured)	Premiun	n Paid with App	lication:					
2.	NALC	Member's Inforr	nation: (Please	e print or type)			Social	Security No.		
	Name									
				(Middle Initial)			NALC	Branch No.		
							Member's S	ex:		
		State Zip Code					Date of Birth			
	Telepho	one No.(		/ (Mc	/ //Day/Yr)					
3.	Membe	er's Parent Infor								
	Name _	(First)	(Midd	dle Initial)	(Last)		Sex:	□M □F		
					( )					
	City									
	State _			Zip Cod	de		Date of Birth			
	Telepho	one No.(		// (Mo/Day/Yr)						
							(inc	<i></i>		
••	Payroll Deduction: I hereby authorize the U.S. Postal Service: (1) to deduct from my salary or wages such amou may be required by the United States Letter Carriers Mutual Benefit Association (MBA) to pay premiums due fro for insurance; and (2) to pay the amounts thereof on my behalf to the MBA. The authorization shall continue durit employment in any capacity by the U.S. Postal Service or until canceled by me by written notice to the MBA. Note do authorize deduction of your premium, unless you check a box below. Payroll deductions will start approximate days after the receipt of your application.									
	I do not want to use payroll deduction (check one):						☐ Bill me annually			
5A					ed, treated, tested or disorder such a		or been given	medical advice		
							Yes	No		
	1.	other heart dise			heart attack, stro ory system?	ке,				
	2.	Emphysema or	chronic respira	tory disease?						
	3.	Hepatitis or other	er diseases of t	he liver?						
	4.	Blood disease of	or disorder?							
	5.	Cancer?								
	6.	Diabetes that re	quire insulin?							
	7.	the medical prof	fession for Acq	uired Immune D	th or treated by a leficiency Syndrolomune deficiency	me (AIDS),				
	8.	Within the past diagnostic test,			have any					

5B.	Please list any current medications:									
5C.	Proposed insured height	and weigh	nt							
5D.	Has the proposed insured been:	Disabled or claimed d	lisability?	☐ Yes	□ No					
5E.	For any question <b>5A or 5D</b> above to which you responded YES, please <b>explain</b> fully below:									
		If you need additional spa	ace, use a separate	page.						
	Ownership: The NALC member wind The owner must be in accordance  Name	e with the provisions	s in the USLCI	/IBA Constit		neral	Laws	– LAV	<b>N</b> 1.	
	Address									
	City									
	State	·								
	Relationship to Insured:									
7.	Beneficiary: The beneficiary name  Name	application will	receive the p	proceeds		he ins				
	If you n  Dividends: MBA will use the Paid exception of, the 10-year Renewab		(Option C), ur	lless you inf	orm the N					
	Effective Date: Insurance applied first premium payment, provided the approve this application, the full prany policy herein applied for unle effective date.	e MBA approves this a remium payment will	application and be returned. <i>I</i>	issues a pol <i>lo insuranc</i>	icy of insu e <i>shall b</i>	ırance <b>ecom</b> e	. If Mi	BA do ctive	es not <i>under</i>	
	Replacement: Do you have existin	g life insurance or anr	nuity contracts?	Yes 🗖	No					
	Is this policy intended to replace or If yes, please indicate below	fe insurance or	annuity poli	cy(ies)?	Yes		No			
	Name of Life Insurance Company _			Policy No						
	Address									
	<b>Declaration:</b> I (We) have <b>read</b> this whether to issue a policy on these and answers made in this application to the best of my (our) knowledge a	answers I (We) have on, which includes any	given in this ap	plication. I (\	Ne) <b>repre</b>	esent t	hat all	state	ments	
	WARNING: It is a crime to provio the insurer or any other person. insurance benefits if false inform	Penalties include imp	orisonment an	d/or fines. I	ln additio	n, an i	nsure			
	Signati	ure of NALC Member					Da	te		
	Sic	nature of Parent					Da	te		

PARENT LIFE APP 2015–DC (Rev. 04/15)