

UNITED STATES LETTER CARRIERS MUTUAL BENEFIT ASSOCIATION

APPLICATION FOR GROUP INSURANCE

APPLICANT	Legal Name _____			Address _____ _____	
NATURE OF BUSINESS	LABOR ORGANIZATION	CONTRIBUTION DISTRIBUTION	BRANCH MEMBER	100%	0%
POLICY EFFECTIVE DATE	DAY 1	MONTH	YEAR	DEPOSIT WITH APPLICATION	\$ _____ or 1 month's premium, whichever is less
ELIGIBLE MEMBERS	All active members of the NALC and of Branch _____ in good standing who are letter carriers or other non-supervisory Postal Career Service employees.				
ELIGIBLE DEPENDENTS	None				
OTHER GROUP PLANS	None				
BENEFITS APPLIED FOR	\$ _____ SUPPLEMENTAL TERM LIFE INSURANCE BENEFIT \$ _____ SUPPLEMENTAL ACCIDENTAL DEATH BENEFIT				
	THE APPLICANT hereby declares that the statements and answers contained above are full, complete and true as of the date hereof and expressly agrees that (1) such statements and answers shall constitute the application for and form part of the contract, and (2) the insurance shall become effective in accordance with and subject to the policy to be issued to the Applicant but in no case shall it become effective until the first monthly premium has been paid and this application has been approved by the United States Letter Carriers Mutual Benefit Association at its Executive Office.				

DATED AT \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

USLCMBA \_\_\_\_\_ APPLICANT \_\_\_\_\_

BY \_\_\_\_\_ BY \_\_\_\_\_

SIGNATURE AND TITLE

SIGNATURE AND TITLE