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

LCA/SD

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)
   20 Pay Whole Life Plan
   Paid Up at Age 65 Whole Life Plan
   Whole Life Plan
   10 Year Renewable and Convertible Term Plan
   5 Year Renewable and Convertible Term Plan
   20 Year Term
   Term to Age 65

Coverage Information	$10,000	$25,000	$50,000	$100,000	Other *(Specify)*
Member	❑	❑	❑	❑	❑ ______________
Spouse	❑	❑	❑	❑	❑ ______________
Child	❑	❑	❑	❑	❑ ______________

2. **NALC Member's Information:** *(Please print or type)*

Name ______________________________________ (First) (Middle Initial) (Last)

Address ______________________________________

City ______________________________________

State ____________________ Zip Code ____________

Telephone No.(________) ____________________
Area Code

Social Security No. ____________________

NALC Branch No. ____________________

Member's Sex: ❑ **M** ❑ **F**

Date of Birth ______/____/_____ (Mo/Day/Yr)

3. **Spouse Information:**

Name ______________________________________ (First) (Middle Initial) (Last)

Sex: ❑ **M** ❑ **F**

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:** Has any proposed insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:

	Proposed Insured (s): Member Yes	Member No	Spouse Yes	Spouse No	Child(ren) Yes	Child(ren) No
1. High blood pressure, coronary artery disease, heart attack, stroke, other heart disease or disorders of the circulatory system?	❑	❑	❑	❑	❑	❑
2. Emphysema or chronic respiratory disease?	❑	❑	❑	❑	❑	❑
3. Hepatitis or other diseases of the liver?	❑	❑	❑	❑	❑	❑
4. Blood disease or disorder?	❑	❑	❑	❑	❑	❑
5. Cancer?	❑	❑	❑	❑	❑	❑
6. Diabetes that require insulin?	❑	❑	❑	❑	❑	❑
7. Have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder?	❑	❑	❑	❑	❑	❑
8. Within the past five (5) years been advised to have any diagnostic test (except those related to the Human Immunodeficiency Virus (AIDS virus)), hospitalization or surgery?	❑	❑	❑	❑	❑	❑

(OVER)

6B. Please list any current medications: ______________________________

____

6C. Proposed insured height ____________ and weight ______________

	Proposed Insured (s):					
	Member		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
6D. Within the past five (5) years, has any of the proposed insured been: Disabled or claimed disability?	❑	❑	❑	❑	❑	❑

6E. For any question **6A or 6D** above which has a YES response, please **explain** fully below:

____

____

____

____

If you need additional space, use a separate page.

7. Ownership: The NALC member will be the policy owner unless otherwise specified below.
The owner must be in accordance with the provisions in the USLCMBA Constitution General Laws – LAW 1.

Name ______________________________
(First) (Middle Initial) (Last)

Address ______________________________

City ______________________________

State ______________________ Zip Code ______________

Relationship to Insured: ________________ Social Security No.: ____________________

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, unless you inform the MBA otherwise. (Note that the Term Life policies will use the dividends on deposit option if dividends are paid).

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: Do any proposed insureds have existing life insurance or annuity contracts? Yes ❑ No ❑
Is this policy intended to replace or change any existing life insurance or annuity policy(ies)? 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.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

______________________________ ______________
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