Application for Membership and Insurance with the UNITED STATES LETTER CARRIERS MUTUAL BENEFIT ASSOCIATION

Home Office: 100 Indiana Avenue N.W., Washington, DC 20001, Phone (202) 638-4318
Executive Office: Nashville, TN nalc.org/mba

A Fraternal Benefit Society

Individual Disability Income

1. Benefit Period Desired (check one): ❑ **6 Month** ❑ **12 Month**

2. Benefit Amount Desired: (check one): ❑ **$650 / Month** ❑ **$1,350 / Month** ❑ **$2,000 / Month**

3. NALC Member's Name: _____ NALC Branch No. _____

   Social Security Number: _____ Sex _____ (M or F) Date of Birth _____ (Mo. / Day / Yr.)

4. Home Address: _____
   Street City State Zip Code

   Telephone No.: (_____)_____
   Area Code

5. **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 United States Letter Carriers Mutual Benefit Association ("USLCMBA") 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 twenty-eight (28) days after receipt of your application.

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

   Additional Premium Enclosed: _____

6. **Existing Coverage:** Are you currently covered by an existing disability income insurance policy? ❑ NO ❑ YES

   If "YES", please indicate: Name of Insurance Company: _____ Policy No.: _____

   Is the disability income insurance applied for by this application intended to replace or change any disability income insurance in force, either with the USLCMBA or any other company? ❑ NO ❑ YES

   If "YES", then if the policy being replaced is <u>different than that listed above</u>, provide information on that policy:

   Name of Insurance Company: _____ Policy No.: _____

7. **Medical Information:** Within the last ten (10) years, by a member of the medical profession, have you been diagnosed, treated, hospitalized or recommended for treatment, including prescription drug use, for any of the following:

   1. Disease or disorder of the circulatory system including but not limited to high blood pressure, coronary artery disease, heart attack, stroke? ❑ **NO** ❑ **YES**
   2. Disease or disorder of the respiratory system including but not limited to emphysema, CoVid-19, chronic respiratory disease? ❑ **NO** ❑ **YES**

3. Disease or disorder of the brain or nervous system including but not limited to Multiple Sclerosis (MS), Parkinson's Disease, Epilepsy?	❑ NO	❑ YES
4. Disease or disorder of the liver including but not limited to Hepatitis?	❑ NO	❑ YES
5. Disease or disorder of the abdominal organs including but not limited to the stomach, intestines, pancreas, rectum, colon?	❑ NO	❑ YES
6. Disease or disorder of the eyes, ears, nose or throat including but not limited to vertigo, sleep apnea?	❑ NO	❑ YES
7. Disease or disorder of the blood, skin, thyroid, lymph or other glands including but not limited to lymphoma?	❑ NO	❑ YES
8. Cancer, tumor, cyst or nodule?	❑ NO	❑ YES
9. Disease or disorder of the genito-urinary glands including but not limited to tuberculosis, gonorrhea?	❑ NO	❑ YES
10. Diabetes that requires insulin?	❑ NO	❑ YES
11. Disease or disorder of the skeletal system including but not limited to Osteoporosis, Leukemia?	❑ NO	❑ YES
12. Arthritis, injury or disorder of the spine, neck or back, jaw, arm, leg, shoulder, wrist, hand, hip, knee, ankle, or foot?	❑ NO	❑ YES
13. Mental health including but not limited to Bipolar disorder, Depression?	❑ NO	❑ YES
14. Gynecological diseases including but not limited to Cervical Dysplasia, incontinence?	❑ NO	❑ YES
15. Sexually transmitted diseases including but not limited to Hepatitis B?	❑ NO	❑ YES
16. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	❑ NO	❑ YES
17. Disease or disorder of the immune system including but not limited to, Lupus, Autoimmune Lymphoproliferative Syndrome (ALPS), Severe Combined Immunodeficiency (SCID) (but excluding Human Immunodeficiency Virus (HIV))?	❑ NO	❑ YES

This information will not be used for policy issue purposes, but may be used for the pre-existing condition limitation of the policy.

8. **Effective Date:** Insurance applied for by this policy application will become effective on the date the USLCMBA receives the first premium payment, provided the USLCMBA approves this application and issues a policy of insurance.

   I understand and agree that this application, as completed and signed, will form the basis of the policy issued.

   I understand and agree that for any person covered by the policy applied for by this application, benefits will not be paid for any condition for which symptoms existed that would cause an ordinary prudent person to seek diagnosis, care or treatment within a one (1) year period preceding the policy date, or for which medical advice or treatment was recommended or received by a physician within a two (2) year period preceding the policy date, unless you have gone for a period of one (1) year while the policy is in force without receiving any medical advice or treatment for that condition. I authorize physicians and medical institutions for furnish the USLCMBA with information regarding medical history, physical condition and diagnosis of the insured.

   I have considered my present health insurance coverage and income, and feel that the policy applied for by this application is the amount and kind of insurance I need to supplement my present health insurance coverage and is suitable for me.

9. **Fraud Notice:** The falsity of any statement in this application shall not bar the right to recovery under the policy issued unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the USLCMBA. **For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

   By signing below, I hereby certify and confirm that I am an active member of the National Association of Letter Carriers (NALC) and current employee of the U.S. Postal Service, and that I will be the Insured, Owner, and Payor of the Individual Disability Income policy associated with this application.

Signature of Member _____ Date _____