HOSPITAL PLUS 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 _____ (M or F) 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.

Fraud Notice - 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.

Signature of Member _____ Date _____

Do Not Write Below

USPS Finance Number

_____

_____
St. Code