



Application for Individual Flexible Premium Deferred Annuity with the UNITED STATES LETTER CARRIERS MUTUAL BENEFIT ASSOCIATION A Fraternal Benefit Society

100 Indiana Avenue N.W. • Washington, DC 20001 • 202-638-4318

MBA Family Retirement Savings Plan

1. NALC Member's Information: (Please print or type) Social Security No. _____

Name _____
(First) (Middle Initial) (Last)

Address _____ NALC Branch No. _____

City _____ State _____ Zip _____

Telephone No. (_____) _____ Member's sex M F
(Area Code)

2. **Ownership:** The insured (annuitant) will be the policy owner of his/her policy, and must be 18 years of age or older.
The owner (family member) must be in accordance with the provisions in the USLCMBA Constitution General Laws – LAW 1.

Owner _____
(First) (Middle Initial) (Last)

Address _____

City _____ State _____ Zip _____

Social Security No. _____ Sex M F Date of Birth ____/____/____

3. Relationship of Owner (annuitant) to NALC Member: _____

The MBA Family Retirement Savings Plan is available to Children, Grandchildren, Great Grandchildren, Step Children, Step Grandchildren and Step Great Grandchildren of a NALC member.

4. Initial Premium Amount (must be at least \$1,000) \$ _____
 Subsequent Planned Premium Amount (suggested monthly amount must be at least \$25) \$ _____
Planned Premium Payment Frequency: Annual Monthly

5. **Will this policy be used as a:** *(Select only one option)*

- Traditional Individual Retirement Account Roth Individual Retirement Account Non-qualified Deferred Annuity

6. **Beneficiary:** The beneficiary(ies) named below of this policy application will receive the proceeds when the insured dies:

Name	Address	Relationship	Social Security No
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you need addition space, use a separate page.

7. **Effective Date:** Your plan will be effective on the date the initial premium is paid.

8. **Replacement:** Do you have existing life insurance or annuity contracts? Yes No
 Is this policy intended to replace or change any existing life insurance or annuity policy? Yes No
 If yes, indicate:

Name of Insurance Co. _____ Policy No. _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

Proposed Insured's (Annuitant's) Signature _____ Date _____
 NALC Member Applicant's Signature _____ Date _____

Do Not Write Below

USPS Finance Number

St. Code

