

# Application for Life Insurance with the UNITED STATES LETTER CARRIERS MUTUAL BENEFIT ASSOCIATION (MBA)

Home Office: 100 Indiana Avenue N.W., Washington, DC 20001 • Executive Office: Nashville, TN

**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)
- 10 Year Renewable and Convertible Term Plan
- 20 Pay Whole Life Plan
- Paid Up at age 65 Whole Life Plan
- Whole Life Plan
- Universal Life Plan

Coverage Information	\$10,000	\$25,000	\$50,000	\$100,000	Other (Specify)
Member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

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

**Social Security No.** \_\_\_\_\_

Name \_\_\_\_\_  
(First) (Middle Initial) (Last)

**NALC Branch No.** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

**Member's Sex:**  M  F

State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Date of Birth**

Telephone No. (\_\_\_\_\_) \_\_\_\_\_  
Area Code

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(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 <small>(Mo/Day/Yr)</small>	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 of the Proposed Insured been told by a healthcare professional that he or she has or had:

	Proposed Insured (s):					
	Member		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. High blood pressure, coronary artery disease, heart attack, stroke, other heart disease or disorders of the circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Emphysema or chronic respiratory disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Hepatitis or other diseases of the kidney?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Blood disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(OVER)

<b>Member</b>	<b>Spouse</b>	<b>Child(ren)</b>
<b>Yes No</b>	<b>Yes No</b>	<b>Yes No</b>

6. Diabetes that require insulin?  Yes  No  Yes  No  Yes  No
7. Ever tested positive for the HIV virus as indicated by the results of the Elisa, Elisa, Western Blot test series?  Yes  No  Yes  No  Yes  No
8. Within the past five (5) years been advised to have any Diagnostic test, hospitalization or surgery?  Yes  No  Yes  No  Yes  No

6B. Please list any current medications: \_\_\_\_\_  
 \_\_\_\_\_

6C. Proposed Insured height \_\_\_\_\_ and weight \_\_\_\_\_

<b>Proposed Insured (s):</b>					
<b>Member</b>	<b>Spouse</b>	<b>Child(ren)</b>			
<b>Yes No</b>	<b>Yes No</b>	<b>Yes No</b>	<b>Yes No</b>	<b>Yes No</b>	<b>Yes No</b>

6D. Has any of the proposed Insured been: Disabled or claimed disability?  Yes  No  Yes  No  Yes  No

6E. For any question 6A or 6D above to which you responded YES, please explain fully below:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If you need additional space, use a separate page.

7. **Ownership:** Unless you tell the MBA otherwise, the NALC member will be the owner of each policy.

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 (Option C), unless you inform the MBA otherwise (with the exception of, the 10-year Renewable and Convertible Term Life policies. The MBA will use dividends on deposit).

10. **Effective Date:** Insurance applied for in this policy application will become effective only on the Effective Date, which is the later of: (a) the date on which the MBA approves this application and issues a policy of insurance; and (b) the date on which the MBA receives the first premium payment. **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:** Is this policy or (are these policies) intended to replace or change any life insurance or annuity (ies) policy(ies) that you presently own? 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, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated 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 If proposed for insurance <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Legal Guardian	_____ Date