Application

PLEASE READ INSTRUCTIONS AND COMPLETE ALL SECTIONS.

Print clearly in blue or black ink. Cross out and initial changes (no white out).

1 PERSON TO BE INSURED

For office use (Policy Number)

Name *(Last, First MI)*	Rank/Title	Social Security Number
E-Mail (❑ *Personal* ❑ *Work)*	Gender ❑ Male ❑ Female	Birth Date *(mm/dd/yyyy)*
Address *(Street, City, State, ZIP)*		Phone (❑ *Cell* ❑ *Home* ❑ *Work)*
Alternate Address *(Street, City, State, ZIP)*		Alt. Phone (❑ *Cell* ❑ *Home* ❑ *Work)*
Applying as: ❑ Member ❑ Spouse ❑ Child ❑ Grandchild	Member Name *(if not the insured)*	Member SSN *(if not the insured)*

If Applying As Member: ❑ Active ❑ Guard ❑ Reserve ❑ Retired ❑ Veteran *(FL, HI, MD, NC, OK, SC, VA residents only)*

❑ Army ❑ Air Force ❑ Navy ❑ Marines ❑ Coast Guard | If Guard/Reserve: ❑ Full Time ❑ Part Time

2 POLICY SELECTION

Policy *(select only ONE BOX)*

TERM LIFE *(age 18 and over)*

- ❑ Level Term I *(under age 50, nicotine under age 40)*
- ❑ Level Term II for _____ years
- ❑ Five-Year Renewable Term

VALUE-ADDED WHOLE LIFE

- ❑ Pay to age 100
- ❑ Pay for _____ years *(30, 20 or 7)*
- ❑ Single payment *(Whole Life only)*

❑ Replacing existing AAFMAA policy *(form required)*

Insurance Amount $

Monthly Premium $

Payment Type *(see Instructions)*	**Deposit Required**
❑ Monthly military allotment*	*2 months*
❑ Monthly bank account withdrawal ..... *("VOID" check also required with deposit)*	*1 month*
❑ Credit card *(signed form required)*	*See instructions*
❑ Quarterly bill	*3 months*
❑ Semiannual bill	*6 months*
❑ Annual bill	*12 months*
❑ Single payment *(Whole Life only)*	*2 months*

DEPOSIT next to selected Payment Type above is REQUIRED.

Payer of Policy	Name *(if other)*	Phone *(best contact)*	SSN *(if other)*
❑ Insured			
❑ Other *(complete boxes)*	Address *(if other)*		Relation *(if other)*

3 BENEFICIARY SELECTION

❑ **On attached Beneficiary Designation form.**

Upon the death of the insured, pay the benefit in equal shares to the surviving primary beneficiaries, or to the surviving contingents if all primaries are deceased. If no beneficiaries are living, pay the benefit to (or to the estate of) the owner.

Name *(Last, First MI)*	**SSN** *(or TIN)*	**Relationship**	**Birth Date** *(mm/dd/yyyy)*
Primary*(ies)*			
Contingent*(s)* ❑ All children of the insured (born or adopted)			

Do not write in this space. Application processing at Ft. Myer, VA		Comments
Date Received *(mm/dd/yyyy)*	Deposit Received	
Date Accepted *(mm/dd/yyyy)*	Identification Received	
Recommendation ❑ Accept ❑ Withdraw ❑ Defer	Rate Class ❑ Super ❑ Select ❑ Standard	Signature of AAFMAA Reviewing Authority

Continued on reverse side

**If Active Duty, AAFMAA will provide information for starting an allotment.*

4 MEDICAL INFORMATION

Read Instructions page for medical requirements.

Answer ALL medical questions accurately and completely. Failure to do so could invalidate this coverage.

1. Height *(feet/inches):* _____ Weight *(pounds)* _____ Date of last physical exam *(mm/dd/yyyy):* _____

Has the insured ever had or been diagnosed or treated for any of the following?	YES	NO
2. Shortness of breath, chest pain, palpitations, heart abnormality, anemia, blood or blood vessel disease or hypertension		
3. Tuberculosis, asthma, pleurisy, or any disorder of the lungs		
4. Convulsions, epilepsy, stroke, loss of consciousness, brain or nervous disorder, anxiety, depression or mental illness		
5. Diabetes, albumin, sugar, pus, or blood in urine; any disease/disorder of the kidneys, bladder or prostate		
6. Peptic ulcer, jaundice, gall stones, chronic diarrhea or any digestive or intestinal disorder within the past five years		
7. Growth, tumor, malignancy or cancer, disease of the skin, bones or joints; arthritis or rheumatism		
8. Any illness or injury for which a physician or other practitioner was consulted; disease or physical deformity, or surgical procedure or hospitalization within the past five years		
9. Excessive alcohol or drug use, or advice to limit, cease or receive counseling for alcohol or drug use		
10. Any disease or disorder resulting in rejection, higher premiums, or a reduction in insurance by any insurance company		
11. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS-related conditions		
12. In the last 12 months, ANY use of cigarettes, cigars, pipes, snuff, chewing tobacco, nicotine gum or other nicotine delivery system		
13. In the last five years, ANY prescribed medication (**PLEASE LIST**)		
Has the insured experienced any of the following?		
14. In the next 12 months, scheduled or anticipate any surgical procedures **(PLEASE DESCRIBE)**		
15. In the last five years, conviction of Driving While Intoxicated, Driving Under the Influence, two or more moving violations, or had a driver's license suspended or revoked		
16. In the next 12 months, participated in or plan to participate in automobile racing, rock or mountain climbing, ultra light flying, hang gliding, ballooning, skydiving, powerboat racing, motorcycle racing, scuba diving, commercial or private piloting, or any other hazardous occupation, activities or sports (for aviation, complete Aviation Questionnaire from www.aafmaa.com/forms)		
17. In the next 12 months, plan to travel to or reside in a foreign country		
Has any parent or sibling had any of the following?		
18. Diabetes, cancer, heart or kidney disease, mental illness, suicide or any other hereditary disease (If yes, provide relationship, illness, age of onset, current age if living or age at death.)		

Questions answered "YES" must include details on a separate page signed and dated by the insured.

5 CERTIFICATION

I hereby apply to the Army and Air Force Mutual Aid Association (AAFMAA) for insurance as provided by its Constitution. I attest that the statements and answers in all parts of this application, to the best of my knowledge and belief, are complete and true, and will be the basis for and a part of any insurance issued. I understand that any photocopy amendment or statement I submit may be accepted and relied upon by AAFMAA, in its sole and absolute discretion, and treated as a valid original, and will be included in any approved policy that is issued and delivered to the owner. I understand that the USA PATRIOT Act requires AAFMAA to verify the identity of insureds and owners, and that I must provide documents and information that may be verified by third party sources. I understand that all documents I provide will be retained by AAFMAA.

I understand insurance coverage cannot begin until the deposit is received. I understand that the insurance coverage applied for will be effective conditionally from the date AAFMAA receives my application, deposit, identification and required medical information, whichever is later. If I die before this application is approved and a policy issued, and it is determined by AAFMAA, pursuant to its rules and procedures, that I am not acceptable to AAFMAA for the insurance coverage applied for as of the date of the application, there is no insurance coverage, no death benefit will be payable, and any deposit paid will be refunded. Based on my health and other factors affecting my insurability, I may be offered a higher premium rate or my application may be withdrawn.

If I have chosen to pay by bank account withdrawal or monthly military allotment, I hereby authorize AAFMAA to contact the payment provider on my behalf to start, increase, decrease or stop my payment when necessary to collect amounts currently due. I understand that AAFMAA cannot start or increase active duty allotments.

I have read the Instructions page, completed all sections and enclosed required medical and identification documents.

Signature of Insured	Date Signed *(mm/dd/yyyy)*

Policy Owner ***(see instructions)***	Name *(if other)*	Birth Date *(if other)*	SSN *(if other)*
❑ Insured			
❑ Other *(complete boxes)*	Address *(if other)*		Relation *(if other)*

Signature of Owner	Date Signed *(mm/dd/yyyy)*

Instructions

Please READ THESE INSTRUCTIONS thoroughly. Incomplete applications cannot be processed!

1 PERSON TO BE INSURED

Alternate Address - If you move often, give the address of a relative or close friend who will always be in contact with you.

Guard/Reserve - "Full Time" means daily active duty. If you serve on weekends or for annual training, select "Part Time".

Identification - Provide a copy of your government issued identification (ID), such as Driver's License (state or US territory) or Passport. *Do not copy your military identification or common access card, as their duplication is prohibited by law.*

- ***New Members*** - if sending Driver's License or Passport, ALSO provide copy of most recent LES or military physical
- ***Children under age 18*** - substitute ID of parent/guardian
- ***Honorably discharged veterans*** *(FL, HI, MD, NC, OK, SC or VA residents only) - copy of Form DD-214 or honorable discharge certificate*

2 POLICY SELECTION

Policy - Select only ONE (either Term or Value-Added Whole Life).

Insurance Amount - Choose increments of $10,000. Minimum is $50,000 for term life and $10,000 for whole life. Maximum is $800,000, **including current AAFMAA coverage on the proposed insured**.

Monthly Premium - Enter premium for the selected policy using either the quotes included with this application, our web site or by contacting AAFMAA.

- ***For Level Term II*** - There are six premium classes - Super Select, Select, Standard and Class 1, 2 and 3. Enter premium and send deposit for **Select** class. **If you are approved at another class, AAFMAA will issue the policy and mail it to you, along with your actual premium amount.** Upon receipt, you will have a 10-day "free look" period to accept or reject the policy.
- ***For single payment*** - Enter premium and send deposit for two months of "Pay to age 100" premiums. When the application is approved, AAFMAA will bill you for the remaining amount due.

Payment Type - Select one. **APPLICATIONS CANNOT BE PROCESSED WITHOUT A DEPOSIT. Enclose the amount shown in the Deposit column next to the selected payment plan.**

- ***Monthly military allotment*** - A two month deposit is required. AAFMAA can start and increase allotments for Army and Air Force Retirees only. We cannot start or increase allotments for Active Duty personnel. If we cannot start your allotment, we will provide you with instructions on how to do so. If the insured is not the allotter, an Allotment Authorization form must be submitted (from AAFMAA or www.aafmaa.com/forms).
- ***Monthly bank withdrawal (EZ-Pay)*** - **Enclose a blank check marked "VOID" or deposit slip** with bank routing numbers, in addition to your one month deposit amount. Available only for U.S. depository institutions for funds held and disbursed in U.S. dollars.
- ***Credit card*** - Enclose a completed and signed Credit Card Payment form (from AAFMAA or www.aafmaa.com/forms). Under the Payment section, on the first line select allocation (deposit) and frequency (one time). On the second line select desired premium (monthly, quarterly, semiannual or annual) and frequency (recurring). AAFMAA will fill in the appropriate amounts.

Replacement - If this policy will replace an existing AAFMAA policy, a signed AAFMAA resignation form is required. Please contact your AAFMAA representative.

3 BENEFICIARY SELECTION

For each beneficiary, provide name, Social Security Number (or Tax Identification Number), relationship to the insured and birth date. A more detailed Beneficiary Designation form is available upon request or at www.aafmaa.com/forms. By law in most states, payments to minor children designated as beneficiaries must be entrusted to a legally appointed guardian until they reach the age of majority (usually 18). Before designating a minor, we strongly recommend you to check with the state where the beneficiary resides to determine their requirements.

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4 MEDICAL INFORMATION

Applicants must accurately and completely answer ALL medical questions on the application. Failure to provide accurate, complete responses will invalidate the insurance coverage. **Provide explanations for "yes" answers.** Based on underwriting review, additional information may be requested.

Applying for Level Term I:	Requirement A.
Applying for Level Term II and:	**Submit copies of the medical requirements as listed:**
Active Duty or **Full-Time Guard/Reserve**	Requirement B.
Part Time Guard/Reserve, Retired, Veteran, Spouse or Child (age 18-23)	Requirement C.
Applying for Value-Added Whole Life and:	**Submit copies of the medical requirements as listed:**
Active Duty or Full Time Guard/Reserve • Under age 40 AND • "No" for medical questions 2-11 & 13	Requirement A.
Active Duty or Full Time Guard/Reserve • Over age 39 OR • "Yes" for medical questions 2-11 & 13	Requirement B.
Part Time Guard/Reserve, Retired, Veteran or Spouse	Requirement C.
Spouse of Active Duty Member • Under age 40 AND • "No" for medical questions 2-11 & 13 AND • Applying for a policy of $300,000 or less	Requirement A.
Child or Grandchild • Age 6 months - 23 years AND • Applying for a policy of $100,000 or less • Applying for a policy over $100,000	Requirement A. Requirement D.

REQUIREMENT A.

No medical records are required to be sent with application. However, AAFMAA may subsequently request medical information.

REQUIREMENT B.

Most recent copy of your military exam completed in the **last 5 years** to include:

- Medical exam with **blood/urine tests***
- Medical history
- Age 50+ - PSA test (males) / Age 55+ - EKG test

REQUIREMENT C.

Your most recent (within the **last 12 months**) of each:

- Physical/clinical exam with blood/urine tests*
- Age 50+ - PSA test (males)
- Age 55+ - EKG test

REQUIREMENT D.

- Age 6 months - 6 yrs: Well baby statement
- Age 7-14 yrs: Routine/school physical within 12 months
- Age 15-23 yrs: Physical exam with blood/urine tests within 12 months

***Blood Chemistry:** Glucose, BUN, Alk Phos, AST (SGOT), ALT (SGPT), GGT, Triglycerides, Cholesterol, HDL Chol, Chol/HDL Ratio, LDL, HIV. **Urinalysis:** Protein, Glucose. If you cannot provide required medical information, please contact AAFMAA for other arrangements. AAFMAA may arrange an exam at our expense.

5 CERTIFICATION

Insured - Signature required on all applications (must be current date).

Child - If the insured is under age 18, parent or guardian must sign as the insured and provide ID (see section 1).

Owner - Select one. The owner controls policy, designates beneficiary and receives all policy correspondence. If the insured is not the owner, signature of the owner is also required.

Power of Attorney - Persons using a POA to complete the application must submit a copy of their POA and the AAFMAA Power of Attorney Amendment (available from AAFMAA or at www.aafmaa.com/forms). Please follow the instructions on the Amendment for signing and submitting the application.