

ANNUITYLife Insurance Application



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|--|-------|--|--|---------------------------------------|--|
| 1. PERSONAL | | | | <i>For office use (Policy Number)</i> | |
| Insured Name (<i>Last, First MI</i>) | | Rank/Title | | Social Security Number | |
| Email (<input type="checkbox"/> <i>Personal</i> <input type="checkbox"/> <i>Work</i>) | | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | | Birth Date (<i>mm/dd/yyyy</i>) | |
| Street | | Phone (<input type="checkbox"/> <i>Cell</i> <input type="checkbox"/> <i>Home</i> <input type="checkbox"/> <i>Work</i>) | | | |
| City | State | Zip | Phone (<input type="checkbox"/> <i>Cell</i> <input type="checkbox"/> <i>Home</i> <input type="checkbox"/> <i>Work</i>) | | |
| Insured is applying as (<i>select one</i>) <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Grandchild | | | Member Name (<i>if not the Insured</i>) | | Member SSN (<i>if not the Insured</i>) |
| Military Status <input type="checkbox"/> Active <input type="checkbox"/> Guard <input type="checkbox"/> Reserve <input type="checkbox"/> Retired <input type="checkbox"/> Veteran | | | Military Service <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard | | |

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| 2. INSURANCE | | |
| Single Premium Payment \$ | Coverage Amount (<i>if known</i>) \$ | Policy Delivery Preference: <input type="checkbox"/> Electronic <input type="checkbox"/> Paper |

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|---|------------------------|----------------------------------|---|
| 3. BENEFICIARY. (<i>Equal shares to surviving primaries, else contingents, else estate.</i>) | | | |
| PRIMARY: Name (<i>Last, First MI</i>) | Social Security Number | Birth Date (<i>mm/dd/yyyy</i>) | Relationship to Insured |
| PRIMARY: Name (<i>Last, First MI</i>) | Social Security Number | Birth Date (<i>mm/dd/yyyy</i>) | Relationship to Insured |
| CONTINGENT: Name (<i>Last, First MI</i>) | Social Security Number | Birth Date (<i>mm/dd/yyyy</i>) | Relationship to Insured |
| CONTINGENT: Name (<i>Last, First MI</i>) | Social Security Number | Birth Date (<i>mm/dd/yyyy</i>) | Relationship to Insured |
| <input type="checkbox"/> All children of Insured (born or adopted) as Contingents. | | | For a detailed form go to www.aafmaa.com/forms |

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| 4. MEDICAL | YES | NO |
| 1. Are you presently in a hospital, nursing home or treatment facility? | | |
| 2. Are you confined to a bed? | | |
| 3. Have you been diagnosed with a terminal illness expected to result in death within two years? | | |

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|---|-------------------------|--|----------|
| Do not write in this space. Application processing by AAFMAA | | | Comments |
| Date Received | Deposit Received | Recommendation <input type="checkbox"/> Accept <input type="checkbox"/> Withdraw <input type="checkbox"/> Defer | |
| Date Accepted | Identification Received | Signature of AAFMAA Reviewing Authority | |

5. AUTHORIZATION

I hereby apply to AAFMAA for insurance as provided by its Constitution. I represent that my statements and answers are true to the best of my knowledge. I understand that AAFMAA will rely on my statements and answers in determining my eligibility for insurance and receiving my application. I also understand that any false or incomplete statement or answer which materially affects the acceptance or the risk or the hazard assumed may result in loss of coverage under the policy to which this application is attached. 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 federal law requires AAFMAA to verify the identity of insureds and owners. I understand that all documents I provide will be retained by AAFMAA.

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 shall be no insurance coverage, no death benefit will be payable, and any deposit paid will be refunded.

I authorize any health care providers, pharmacy benefit manager or other pharmaceutical firm, insurance companies, MIB, Inc., consumer reporting agency, the Department of Motor Vehicles, financial institution, or employer having information about my physical or mental condition, prescription drug records, financial status, employment status or other relevant information about me, to give all information to AAFMAA to determine eligibility for insurance or benefits. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. I authorize AAFMAA to make a brief report of my personal health information to MIB. Information obtained may be released to persons performing business duties as delegated or contracted for by AAFMAA related to my application and subsequent insurance related functions, as permitted or required by law, or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I agree this authorization is valid for 24 months, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. For purposes of collecting information in connection with a claim for benefits, this Authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by written request to AAFMAA; (2) revocation of this authorization will not affect any prior action taken by AAFMAA in reliance upon this authorization; and (3) failure to sign or revocation of this authorization may impair AAFMAA's ability to evaluate applications or claims and may be the basis for denying this application or claim for benefits.

- I AGREE for AAFMAA to obtain information from Experian solely to verify my identity and military service from my personal credit report or other sources, and provide this written consent as required by the Fair Credit Reporting Act. *(Required - you must check this box.)*
- I AGREE for AAFMAA to use my phone numbers to verify my identity by providing to a third-party to send a One-Time Password via SMS text message. Mobile messaging rates may apply. *(Optional - check box if desired.)*

Privacy Policy information is available at www.aafmaa.com/AboutAAFMAA/PrivacyPolicy.aspx or by mail by calling 1-877-298-2263.

Insured Signature Required

| | | |
|--|---|--------------------------|
| Insured Signature <i>(Parent if under age 18)</i> | Insured Printed Name <i>(First MI Last)</i> | Date <i>(mm/dd/yyyy)</i> |
| Drivers License Number <input type="checkbox"/> <i>Not a licensed driver</i> | State of Issue <i>(Two letter)</i> | |

7. OWNER. *(To designate someone other than the Insured as Owner.)*

| | | | | |
|---|-------|-----|---|---|
| Owner Name <i>(Last, First MI)</i> | | | Relation to Insured | Social Security Number |
| Street | | | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Phone <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work |
| City | State | Zip | E-mail <input type="checkbox"/> Personal <input type="checkbox"/> Work | |
| Owner Signature <i>(if not the Insured)</i> | | | Owner Printed Name <i>(First MI Last)</i> | Date <i>(mm/dd/yyyy)</i> |

Notice of MEC Status



For **ANNUITY**Life Insurance

Please read the following notice and acknowledge by signing at the bottom of this form.

1. NOTICE

Since **ANNUITY**Life Insurance is a life Insurance policy paid with a single premium, the IRS classifies it as a Modified Endowment Contract (MEC) under the Technical and Miscellaneous Revenue act of 1988 (TAMRA). There are several tax implications you should be aware of:

1. When you die, the death benefit is paid tax free to your beneficiaries.
2. Your **ANNUITY**Life Insurance earns interest every month. Those earnings are not taxed as you earn them. They are only taxed if you take a loan from or cash surrender your policy.
3. If you have multiple **ANNUITY**Life Insurance policies, **the IRS requires that all policies issued by the same insurer to the same policyholder in the same calendar year be aggregated for purposes of determining the amount of any distribution that is taxable as gross income.**

Therefore, if you decide to cash surrender one of several policies purchased during the same calendar year, you will have to pay taxes on the interest earned for **all** of the policies with that first policy. When you cash surrender subsequent policies, since you have already paid some or all of the taxes, you will pay less tax on the gain for those subsequent policies.

Ultimately, if all of the policies are surrendered, the amount of total taxes will be the same, because the tax basis of the subsequent policies will be increased to reflect the taxes already paid.

4. Any withdrawals before age 59 ½ are subject to a 10% penalty on the amount of any gain.

Although **ANNUITY**Life Insurance policies have a slightly reduced tax benefit if they are cashed in separately, they still serve as a stable retirement planning tool. They are good alternatives to annuities, which immediately become taxable upon the death of the owner. All AAFMAA life insurance benefits pass tax-free to beneficiaries. **ANNUITY**Life Insurance can be appropriate for members who do not qualify for other insurance products, for members looking for a way to leave a tax-free inheritance to family members, or for members who wish to annuitize their policies and receive a steady stream of income for the remainder of their life.

2. SIGNATURE

I have read and acknowledge my understanding of this notice. I understand AAFMAA does not provide tax advice and that I should consult a tax advisor if I have any tax-related questions.

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|-----------------|------------------------|-------------------|
| Owner Signature | Social Security Number | Date (mm/dd/yyyy) |
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