

# Wealth Builder Life Insurance Application



<b>1. PERSONAL</b>			<i>For office use (Policy Number)</i>		
Insured Name ( <i>Last, First MI</i> )		Rank/Title		Social Security Number	
Email ( <input type="checkbox"/> Personal <input type="checkbox"/> Work)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date ( <i>mm/dd/yyyy</i> )	
Street		Phone ( <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work)			
City	State	Zip	Phone ( <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work)		
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		

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

<b>3. BENEFICIARY. (<i>Equal shares to surviving primaries, else contingents, else estate.</i>)</b>			
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.		<b>For a detailed form go to <a href="http://www.aafmaa.com/forms">www.aafmaa.com/forms</a></b>	

<b>4. MEDICAL</b>			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?				

<b>Do not write in this space. Application processing by AAFMAA</b>			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. Based on my health and other factors affecting my insurability, I may be offered a higher premium rate or my application may be rejected or withdrawn.

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. 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.

If I have chosen to pay by recurring withdrawal from my military allotment, bank account or credit card, 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.

Privacy Policy information is available at [www.aafmaa.com/AboutAAFMAA/PrivacyPolicy.aspx](http://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> )

### 6. 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"/> <i>Cell</i> <input type="checkbox"/> <i>Home</i> <input type="checkbox"/> <i>Work</i> )
City	State	Zip	E-mail ( <input type="checkbox"/> <i>Personal</i> <input type="checkbox"/> <i>Work</i> )	
Owner Signature ( <i>if not the Insured</i> )			Owner Printed Name ( <i>First MI Last</i> )	Date ( <i>mm/dd/yyyy</i> )

### MIB Disclosure

#### This information is required by MIB, which assists AAFMAA in considering your application.

Information regarding your insurability will be treated as confidential. AAFMAA may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or submit a claim for benefits to such a company, MIB, upon request, will supply each company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

AAFMAA may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).