

Conversion Application



Convert existing term policies to a new Value-Added Whole Life Policy

1. OWNER		For office use (AAFMAA Number)
Name (Last, First MI)	Social Security Number	Phone <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Mailing Address	Email <input type="checkbox"/> Personal <input type="checkbox"/> Work	

2. INSURANCE COVERAGE		
Insured Name (Last, First MI)	Policy Number(s) To Convert	
Policy (select only ONE BOX)	Amount of Term To Retain*	Amount To Convert (min \$10,000)
<input type="checkbox"/> Pay for life <input type="checkbox"/> Single payment	\$	\$
<input type="checkbox"/> Pay for _____ years (choose 30, 20 or 7 years)	Nicotine Used In Last 12 Months	Monthly Premium
	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$

* Minimum \$50,000. If amount retained is left blank, term policy will be resigned.

3. PAYMENT SELECTION		Applications cannot be processed without a deposit.
Payment Type	Required Deposit	
<input type="checkbox"/> Military allotment monthly	2 months	
<input type="checkbox"/> Checking account monthly (EZPay)* ...	1 month	
<input type="checkbox"/> Credit card monthly**	1 month	
<input type="checkbox"/> Bill quarterly	3 months	
<input type="checkbox"/> Bill semiannually	6 months	
<input type="checkbox"/> Bill annually	12 months	
		Account Holder/Payer Name
		Account Holder Mailing Address
		ABA Routing Number (for EZPay <u>only</u> if no voided check)
		Account Number (for EZPay <u>only</u> if no voided check)

4. BENEFICIARY SELECTION			
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) <input type="checkbox"/> All children of the insured (born or adopted)			

5. AUTHORIZATION	
I hereby request that AAFMAA convert the portion of the term life insurance policies indicated above to Value-Added Whole Life Insurance. I authorize any amount of the above term life insurance that I am not retaining to be resigned. I understand that converted coverage cannot begin until the deposit is received and this application is approved. I understand that if the converted policy has not passed the two-year contestability period, any remaining period will be transferred to the new policy.	
Insured Signature	Date Signed (mm/dd/yyyy)
Owner Signature (if not the Insured)	Date Signed (mm/dd/yyyy)

Do not write in this space. Application processing by AAFMAA		Comments
Date Received (mm/dd/yyyy)	Date Accepted (mm/dd/yyyy)	
Deposit Received	Signature of AAFMAA Reviewing Authority	