

Term Application



PLEASE READ INSTRUCTIONS AND COMPLETE ALL SECTIONS.

1. MEMBER INFORMATION			For office use (Policy Number)		
Name (Last, First MI)		Rank/Title		Social Security Number	
Street		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date (mm/dd/yyyy)	
City	State	Zip	Phone <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		
Email <input type="checkbox"/> Personal <input type="checkbox"/> Work			Phone <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		
Military Service <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard			Military Status <input type="checkbox"/> Active <input type="checkbox"/> Guard <input type="checkbox"/> Reserve <input type="checkbox"/> Retired <input type="checkbox"/> Veteran		

2. INSURANCE COVERAGE						
PERSON TO BE INSURED	MEMBER	Insurance Amount (select only one) <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000		Premium (see table below) \$	Deposit (see Section 3) \$	
		Beneficiary Name (Last, First MI)		Social Security Number	Birth Date (mm/dd/yyyy)	Relationship to Insured
		Beneficiary Name (Last, First MI) (share equally)		Social Security Number	Birth Date (mm/dd/yyyy)	Relationship to Insured
	SPOUSE	Insurance Amount (select only one) <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000		Premium (see table below) \$	Deposit (see Section 3) \$	
		Spouse Name (Last, First MI)		Social Security Number	Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
		Beneficiary Name (Last, First MI)		Social Security Number	Birth Date (mm/dd/yyyy)	Relationship to Insured
Beneficiary Name (Last, First MI) (share equally)		Social Security Number	Birth Date (mm/dd/yyyy)	Relationship to Insured		
Policy Delivery Preference: <input type="checkbox"/> Electronic <input type="checkbox"/> Paper						

Monthly Premium for MEN						Monthly Premium for WOMEN					
Issue Age	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	Issue Age	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000
45-49	\$10.28	\$20.62	\$39.03	\$48.27	\$57.78	45-49	\$8.04	\$14.94	\$27.24	\$33.15	\$39.24
50-54	\$12.07	\$25.18	\$48.49	\$60.20	\$72.24	50-54	\$9.41	\$18.44	\$34.48	\$42.22	\$50.19
55-59	\$16.31	\$35.95	\$70.85	\$88.39	\$106.46	55-59	\$12.94	\$27.41	\$53.12	\$65.52	\$78.28
60-64	\$22.37	\$51.36	\$102.84	\$128.71	\$155.33	60-64	\$18.40	\$41.27	\$81.90	\$101.51	\$121.69
65-69	\$28.79	\$67.69	\$136.76	\$171.49	\$207.23	65-69	\$24.64	\$57.13	\$114.84	\$142.68	\$171.33
70-74	\$40.19	\$96.65	\$196.89	\$247.28	\$299.15	70-74	\$35.85	\$85.61	\$173.97	\$216.62	\$260.51

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

3. PAYMENT SELECTION

Payment Type	Deposit Months
<input type="checkbox"/> Checking account monthly (EZPay)* ...	1 month
<input type="checkbox"/> Military allotment monthly*	2 months
<input type="checkbox"/> Credit card monthly.....	(see box on right)
<input type="checkbox"/> Bill quarterly	3 months
<input type="checkbox"/> Bill semiannually	6 months
<input type="checkbox"/> Bill annually.....	12 months

Deposit is REQUIRED with application.

Multiply Premium by Deposit Months for selected Payment Type and enclose check. For credit card, enclose form from www.aafmaa.com.

*Save \$1 per month by choosing this option.

4. MEDICAL INFORMATION

	MEMBER		SPOUSE	
	YES	NO	YES	NO
1. In the past 2 years, have you been diagnosed or treated for any of the following: heart trouble, disorder of the lungs, cancer, stroke, diabetes, liver or kidney disorder/disease, AIDS, AIDS related complex (ARC), AIDS-related conditions or disorder of the immune system?				
2. In the past 2 years, have you been admitted to a hospital, psychiatric or rehabilitation center, nursing home, extended care or special treatment facility?				
3. In the past 3 months, have you consulted a doctor or health care professional, had treatment or any diagnostic health tests?				

Provide explanations for "yes" answers on a separate page signed and dated by the insured. Failure to provide accurate, complete responses will invalidate insurance coverage. Additional information may be requested.

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.

Member Signature	Spouse Signature (if applying for insurance)
Date Signed (mm/dd/yyyy)	Date Signed (mm/dd/yyyy)

Return the following to AAFMAA by mail, email (membership@aafmaa.com) or fax (1-888-210-8201):

- THIS APPLICATION** - completed and signed.
- IDENTIFICATION** - copy of government issued ID such as Driver's License (state or US territory) or Passport.
 - **Active Duty** - Include copy of most recent LES or military physical.
 - **Veterans** - Include copy of Form DD-214 or honorable discharge certificate.
- DEPOSIT CHECK** - if not paying by credit card (Section 3).
- BLANK CHECK MARKED "VOID"** - if paying by bank account withdrawal (Section 3).
- CREDIT CARD FORM** - if paying by credit card (Section 3).
- MEDICAL DOCUMENTS** - if required (Section 4).

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.

WHAT HAPPENS NEXT?

Once you submit your application to AAFMAA, we will:

1. Enter your information in our insurance administration system.
2. Review the insurance you are applying for and your answers to the medical questions.
3. Request any required medical information from you to prove your insurability.
 - a. Active Duty applicants can provide their military physical to see if it fulfills AAFMAA's medical requirements.
4. Determine the final resolution of your application (one of the following three actions):
 - a. Accept and issue policy. AAFMAA will issue your policy and apply your first payment in accordance with your provided payment type.
 - b. Offer the policy at an adjusted benefit amount based on your medical underwriting. AAFMAA will not issue a policy for you unless there is an increased benefit over your existing policy.
 - c. Withdraw or postpone the application based on our underwriting review. AAFMAA will notify you in writing if it must take this action.
5. Deliver Policy. Policy owners may access policies after 5 days from issue on AAFMAA's Member Center at www.aafmaa.com. If you did not select "electronic delivery" as your policy delivery option, you should receive your printed policy 7-10 days after policy issue.