Life Insurance Application

AAFMAA® COMPASSION • TRUST • PROTECTION

Please read Application Instructions page and complete all sections.

For office use (Policy Number)

1. PERSONAL

Insured Name *(Last, First MI)*		Rank/Title	Social Security Number
Email (☐ *Personal* ☐ *Work)*		Gender ☐ Male ☐ Female	Birth Date *(mm/dd/yyyy)*
Street		Phone (☐ *Cell* ☐ *Home* ☐ *Work)*	
City	State / Zip	Phone (☐ *Cell* ☐ *Home* ☐ *Work)*	
Insured is applying as *(select one)* ☐ Member ☐ Spouse ☐ Child ☐ Grandchild	Member Name *(if not the Insured)*		Member SSN *(if not the Insured)*
Military Status ☐ Active ☐ Guard ☐ Reserve ☐ Retired ☐ Veteran		Military Service ☐ Army ☐ Air Force ☐ Navy ☐ Marines ☐ Coast Guard	

2. INSURANCE. *(Select one policy below.)*

TERM LIFE *(age 18 and over)*
- ☐ Level Term I
- ☐ Level Term II for _____ years
- ☐ Five-Year Renewable Term

VALUE-ADDED WHOLE LIFE
- ☐ Pay for life
- ☐ Pay for _____ years (30, 20 or 7)
- ☐ Single payment

Insurance Amount $

Monthly Premium $

Replace Existing AAFMAA Policy? ☐ No ☐ Yes *(form required)*

3. PAYMENT. *(Applications cannot be processed without a deposit.)*

Payment Type	Required Deposit
☐ Military allotment monthly	2 months
☐ Checking account monthly *(EZ-Pay)**	1 month
☐ Credit card monthly	1 month
☐ Bill quarterly	3 months
☐ Bill semiannually	6 months
☐ Bill annually	12 months

***Attach blank check marked "VOID" - not deposit slip.**

Account Holder/Payer Name

Account Holder Mailing Address

Bank Account Number OR Credit Card Number

Bank ABA Routing Number OR Credit Card Expiration Date

Policy Delivery Preference: ☐ Electronic ☐ Paper

4. BENEFICIARY. *(Equal shares to surviving primaries, else contingents, else estate.)*

PRIMARY: Name *(Last, First MI)*	Social Security Number	Birth Date *(mm/dd/yyyy)*	Relationship to Insured
PRIMARY: Name *(Last, First MI)*	Social Security Number	Birth Date *(mm/dd/yyyy)*	Relationship to Insured
CONTINGENT: Name *(Last, First MI)*	Social Security Number	Birth Date *(mm/dd/yyyy)*	Relationship to Insured
CONTINGENT: Name *(Last, First MI)*	Social Security Number	Birth Date *(mm/dd/yyyy)*	Relationship to Insured

☐ All children of Insured (born or adopted) as Contingents.

For a detailed form go to www.aafmaa.com/forms

Do not write in this space. Application processing by AAFMAA			Comments
Date Received	Deposit Received	Recommendation ☐ Accept ☐ Withdraw ☐ Defer	
Date Accepted	Identification Received	Signature of AAFMAA Reviewing Authority	

American Armed Forces Mutual Aid Association • 1856 Old Reston Ave, Ste 200, Reston, VA 20190 • 1-800-522-5221 • www.aafmaa.com

5. MEDICAL

1.	Name *(Last, First MI)*	Height *(feet/inches)*	Weight *(pounds)*	Last physical exam date

Please list all prescribed medication taken in the past five years (or write NONE).

2.	Medicine Name	Reason Taken	Dates	Still taking?

Answer ALL medical questions. Provide explanations for all "YES" answers in the space provided.

Has the proposed Insured ever had or been diagnosed, treated or experienced any of the following?	**YES**	**NO**
3. Shortness of breath, chest pain, palpitations, heart abnormality, anemia, blood, or blood vessel disease or hypertension		
4. Tuberculosis, asthma, obstructive sleep apnea (OSA), pleurisy, or any disorder of the lungs		
5. Convulsions, epilepsy, stroke, loss of consciousness, brain or nervous disorder, post traumatic stress disorder (PTSD), anxiety, depression or mental illness		
6. Diabetes, albumin, sugar, pus, or blood in urine; any disease/disorder of the kidneys, bladder or prostate		
7. Growth, tumor, malignancy or cancer, disease of the skin, bones or joints, arthritis or rheumatism		
8. Excessive alcohol or drug use, or advice to limit, cease or receive counseling for alcohol or drug use		
9. Disease or disorder resulting in rejection, high premiums, or reduction in insurance by any insurance company		
10. Acquired immune deficiency syndrome (AIDS), AIDS Related Complex (ARC), AIDS-related conditions, or HIV		
11. In the last five years, peptic ulcer, jaundice, gall stones, chronic diarrhea or any digestive or intestinal disorder		
12. In the last five years, any illness or injury for which a physician or other practitioner was consulted, disease or physical deformity, or surgical procedure or hospitalization		
13. 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		
14. Requested or received a pension, benefits or payment because of an injury, sickness or disability		
15. In the last 12 months, ANY use of nicotine delivery products (cigarette, e-cigarette, cigar, pipe, snuff, vaping, chewing tobacco, gum, patch, etc.)		
16. In the next 12 months, schedule or anticipate any surgical procedures		
17. In the next 12 months, plan to travel to or reside in a foreign country		
18. In the last or next 6 months, participated 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, request Aviation Questionnaire)		
19. Has any parent or sibling had diabetes, cancer, heart or kidney disease, mental illness, committed suicide or any other hereditary disease? (If yes, provide relationship, illness, age of onset, current age if living or age of death.)		

Provide explanations for "YES" answers here.

If you need more space, complete the Application Addendum form.

6. 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. 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 laaw, 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 DFAS or 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 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 *(Parent if under age 18)*	Insured Printed Name *(First MI Last)*	Date *(mm/dd/yyyy)*
Drivers License Number (☐ *Not a licensed driver)*		State of Issue *(Two letter)*

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

Owner Name *(Last, First MI)*			Relation to Insured	Social Security Number
Street			Gender ☐ Male ☐ Female	Phone (☐ *Cell* ☐ *Home* ☐ *Work)*
City	State	Zip	E-mail (☐ *Personal* ☐ *Work)*	
Owner Signature *(if not the Insured)*		Owner Printed Name *(First MI Last)*		Date *(mm/dd/yyyy)*

Application Addendum

Please use this form if additional space is required for any medical questions answered “YES”.

SIGNATURE. All statements and answers are true to the best of my knowledge.	
Insured Name *(Last, First MI)*	Insured Social Security Number
Insured Signature *(parent/guardian signature if Insured is under age 18)*	Date Signed *(mm/dd/yyyy)*

Application Instructions

AAFMAA®
COMPASSION • TRUST • PROTECTION

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

1. PERSONAL

Please complete all sections.

2. INSURANCE

Identification - Provide a copy of a government issued identification (ID), such as Driver's License (state or US territory) or Passport.

- ***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*** *(in approved states) - copy of Form DD-214 or honorable discharge certificate*

Monthly Premium - Enter premium from quotes included with this application, our web site or by contacting AAFMAA.

- These policies have multiple premium classes determined by health, lifestyle and family history.
  - ***Level Term II*** - Super Select, Select, Standard and Rated 1,2 and 3. Use Select class for premium and deposit.
  - ***Value-Added Whole Life*** - Standard and Rated 1, 2 and 3. Use quoted amount for premium and deposit.

If you are approved at another class, AAFMAA will issue the policy and send 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.

Replace - If this policy will replace an existing AAFMAA policy, contact AAFMAA for a resignation form.

3. PAYMENT

Payment Type **- Enclose the Required Deposit of monthly premiums for the selected payment type**

- ***Military allotment*** - AAFMAA can start and increase allotments for retirees only. We cannot start or increase allotments for Active Duty personnel. If we cannot start your allotment, we will provide you with instructions
- ***EZPay*** - Electronic transfer from you bank checking account. Include **check marked "VOID"** (not deposit slip) with account numbers. Only if voided check is not available, carefully enter bank account information. Only U.S. depository institutions in U.S. dollars.
- ***Credit card*** - Include credit card information if desired. **Credit card will be charged when policy is issued.**

4. BENEFICIARY

Complete on application or a detailed Beneficiary Designation form is available (www.aafmaa.com/forms or contact AAFMAA). 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 encourage you to check with the state where the beneficiary resides to determine their requirements.

5. MEDICAL

Answer ALL medical questions and provide explanation for all "YES" answers. Failure to provide accurate, complete responses will invalidate insurance coverage. Based on underwriting review, additional information may be requested.

6. AUTHORIZATION

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

Child - If the insured is under age 18, parent or guardian must sign in lieu of the Insured and provide ID (see section 2).

Owner - Owner has legal control of 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.

Supplementary Information

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 886-692-6901. 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 offices is 500 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. Apply Deposits
   a. Checks are deposited (cashed) and linked to your application. If AAFMAA issues the policy, it will apply the deposit towards premium.
   b. AAFMAA will store credit card and bank account information while your account is pending. If AAFMAA issues a policy, it will charge the deposit from the credit card or bank account at the time of issue.
3. Review the insurance you are applying for and your answers to the medical questions.
4. Request any required medical from you to prove your insurability.
   a. Active Duty applicants can provide their military physical to see if it fulfills AAFMAA's medical requirements.
   b. For all other applicants AAFMAA provides a paramedical exam at no cost to the insured.
   c. If there is a need to request a copy of your medical records, AAFMAA can assist you in this effort.
5. 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. For **Level Term II & Value Added Whole Life**, AAFMAA may issue the policy at a higher premium amount based on your medical underwriting. AAFMAA will initially charge the anticipated premium applied for and deliver a policy to you for review. At that time, you may decide to make a change in your benefit to reduce your premium, or not accept the policy, within the first 10 days for a full refund.
   c. Withdraw or postpone the application based on our underwriting review. AAFMAA will notify you in writing if it must take this action.
6. 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.