Simple Term Application

Please 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. SIMPLE TERM LIFE INSURANCE

Benefit Amount *(select one)*	Monthly Premium
☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000	$

Monthly Premium can be found on the Supplementary Information page or by scanning the QR code.

3. BENEFICIARIES *(Equal shares to surviving primaries, else contingents, else estate.)*

Name	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
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 beneficiary form go to www.aafmaa.com/forms

4. MEDICAL INFORMATION

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

2. In the last 12 months, have you used nicotine in any form? ☐ Yes ☐ No

3. In the past 3 years, have you received any treatment for OR been diagnosed by a doctor as having heart trouble, cancer, stroke, lung disease, liver disease, kidney disease, AIDS, lupus, ALS, schizophrenia, or dementia? ☐ Yes ☐ No

4. In the past 12 months, have you had diagnostic testing performed or recommended by a doctor for an undiagnosed condition? ☐ Yes ☐ No

5. In the past 5 years, have you received treatment for alcohol abuse or drug abuse? ☐ Yes ☐ No

Provide explanations for "Yes" answers here.

1/2023
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5. PAYMENT *(Deposit for selected payment method is required with application.)*

Recurring Payment Method	Months of Premium	
☐ Military allotment monthly	2	Payer Name *(if not the Insured)*
☐ Checking account monthly *(EZ-Pay)**	1	Payer Mailing Address
***Include blank check marked "VOID" - no deposit slip.**		
☐ Credit card monthly	1	Checking Account OR Credit Card Number
☐ Bill quarterly	3	
☐ Bill semiannually	6	Bank ABA Routing Number OR Credit Card Expiration Date
☐ Bill annually	12	
Deposit Payment Method ☐ Checking account ☐ Credit card		Deposit Checking Account OR Credit Card Number
Policy Delivery Method ☐ Electronic ☐ Paper		Deposit Bank ABA Routing Number OR Credit Card Expiration Date

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 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 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.

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)*

Supplementary Information

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Simple Term Monthly Premiums

	Insurance Amount							
	$50,000	$100,000	$150,000	$200,000	$50,000	$100,000	$150,000	$200,000
Age	**Male Non-Nicotine**				**Female Non-Nicotine**			
25-29	$5	$9	$14	$18	$4	$7	$11	$14
30-34	$6	$11	$16	$22	$5	$9	$14	$18
35-39	$7	$13	$19	$25	$6	$11	$16	$22
40-44	$8	$15	$22	$29	$7	$13	$19	$25
45-49	$11	$20	$30	$40	$10	$18	$27	$36
50-54	$15	$28	$41	$54	$14	$26	$38	$50
55-59	$19	$35	$51	$68	$18	$33	$49	$65
60-64	$32	$59	$86	$115	$29	$53	$78	$104
65-69	$99	$182	$267	$356	$69	$127	$186	$248
70-74	$169	$311	$456	$608	$109	$201	$294	$392
Age	**Male Nicotine**				**Female Nicotine**			
25-29	$6	$11	$16	$22	$5	$9	$14	$18
30-34	$9	$17	$24	$32	$8	$15	$22	$29
35-39	$12	$22	$32	$43	$11	$20	$30	$40
40-44	$16	$29	$43	$58	$14	$26	$38	$50
45-49	$22	$40	$59	$79	$19	$35	$51	$68
50-54	$39	$72	$105	$140	$29	$53	$78	$104
55-59	$54	$99	$146	$194	$45	$83	$122	$162
60-64	$89	$164	$240	$320	$79	$145	$213	$284
65-69	$249	$458	$672	$896	$129	$237	$348	$464
70-74	$349	$642	$942	$1,256	$219	$403	$591	$788

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.