Life Insurance Application

AAFMAA
COMPASSION • TRUST • PROTECTION

Please read Application Instructions page and complete all sections.

For office use (Policy Number)

1. MEMBER INFORMATION

Member Name *(Last, First MI)*	Rank/Title	Member Social Security Number	Purchase Premier Services?
Julie Smart	Ms.		☐ Yes ☒ No

Military Service: ☐ Army ☒ Air Force ☐ Navy ☐ Marines ☐ Coast Guard

Military Status: ☐ Active ☐ Guard ☐ Reserve ☒ Retired ☐ Veteran

PERSONS TO BE INSURED

APPLICANT 1	APPLICANT 2
Relationship to Member *(select one)*: ☒ Member ☐ Spouse ☐ Child ☐ Grandchild	Relationship to Member *(select one)*: ☐ Member ☐ Spouse ☐ Child ☐ Grandchild
Insured Name *(Last, First MI)*: Julie Smart	Insured Name *(Last, First MI)*:
Social Security Number: 575-45-6789	Social Security Number:
Birth Date *(mm/dd/yyyy)*: 12/06/1978	Birth Date *(mm/dd/yyyy)*:
Gender: ☐ Male ☒ Female	Gender: ☐ Male ☐ Female
Preferred Phone (☐ *Cell* ☐ *Home* ☐ *Work*): 8312246576	Preferred Phone (☐ *Cell* ☐ *Home* ☐ *Work*):
Phone (☐ *Cell* ☐ *Home* ☐ *Work*):	Phone (☐ *Cell* ☐ *Home* ☐ *Work*):
Phone (☐ *Cell* ☐ *Home* ☐ *Work*):	Phone (☐ *Cell* ☐ *Home* ☐ *Work*):
Street: 100 Stevens Creek Ave,	Street (☐ *Same as Applicant 1*):
City: Santa Clara; State: CA; Zip: 95050	City: ; State: ; Zip:
E-Mail (☐ *Personal* ☐ *Work*): rodhes.jju@gmail.com	E-Mail (☐ *Personal* ☐ *Work*):

2. INSURANCE COVERAGE

APPLICANT 1	APPLICANT 2
Policy *(select only ONE BOX)* **TERM LIFE** *(age 18 and over)* ☒ Level Term I ☐ Level Term II for_____years ☐ Five-Year Renewable Term **VALUE-ADDED WHOLE LIFE** ☐ Pay to age 100 ☐ Pay for_____years *(choose 30, 20 or 7 years)* ☐ Single payment *(Whole Life only)*	Policy *(select only ONE BOX)* **TERM LIFE** *(age 18 and over)* ☐ Level Term I ☐ Level Term II for_____years ☐ Five-Year Renewable Term **VALUE-ADDED WHOLE LIFE** ☐ Pay to age 100 ☐ Pay for_____years *(choose 30, 20 or 7 years)* ☐ Single payment *(Whole Life only)*
Insurance Amount: $ 300,000.00; Monthly Premium: $	Insurance Amount: $; Monthly Premium: $
Replace Existing AAFMAA Policy? ☒ No ☐ Yes *(form required)*; Policy Delivery Preference ☒ Electronic ☐ Paper	Replace Existing AAFMAA Policy? ☐ No ☐ Yes *(form required)*; Policy Delivery Preference ☐ Electronic ☐ Paper
BENEFICIARY DESIGNATION — **PRIMARY** Beneficiary Name *(Last, First MI)*: JOHN Social Security Number: 575-45-1234; Birth Date *(mm/dd/yyyy)*: 12/01/1984 Relationship to Insured: Spouse	**BENEFICIARY DESIGNATION** — **PRIMARY** Beneficiary Name *(Last, First MI)*: Social Security Number: ; Birth Date *(mm/dd/yyyy)*: Relationship to Insured:
CONTINGENT ☐ All children of Insured (born or adopted) equally ☐ Person listed below Beneficiary Name *(Last, First MI)*: Social Security Number: ; Birth Date *(mm/dd/yyyy)*: Relationship to Insured:	**CONTINGENT** ☐ All children of Insured (born or adopted) equally ☐ Person listed below Beneficiary Name *(Last, First MI)*: Social Security Number: ; Birth Date *(mm/dd/yyyy)*: Relationship to Insured:

A detailed Beneficiary Designation form is available at www.aafmaa.com/forms.

3. MEDICAL INFORMATION

1.	APPLICANT 1			APPLICANT 2		
	Name *(Last, First MI)* Julie Smart			Name *(Last, First MI)*		
	Height *(feet/inches)* 175	Weight *(pounds)* 161	Last physical exam date 06/20/2024	Height *(feet/inches)*	Weight *(pounds)*	Last physical exam date

2. Please list all prescribed medications taken in past five years (or write NONE).

Medicine Name	Reason Taken	Dates	Still Taking?	Medicine Name	Reason Taken	Dates	Still Taking?
Medication for depression		6/01/2014	Yes				

APPLIC 1		Answer ALL medical questions. Provide explanations for all "YES" answers below.	APPLIC 2	
YES	**NO**	**Has the proposed Insured ever had or been diagnosed, treated or experienced any of the following?**	**YES**	**NO**
	X	3. Shortness of breath, chest pain, palpitations, heart abnormality, anemia, blood or blood vessel disease or hypertension		
	X	4. Tuberculosis, asthma, obstructive sleep apnea (OSA), pleurisy, or any disorder of the lungs		
X		5. Convulsions, epilepsy, stroke, loss of consciousness, brain or nervous disorder, post traumatic stress disorder (PTSD), anxiety, depression or mental illness		
	X	6. Diabetes, albumin, sugar, pus, or blood in urine; any disease/disorder of the kidneys, bladder or prostate		
	X	7. Growth, tumor, malignancy or cancer, disease of the skin, bones or joints; arthritis or rheumatism		
	X	8. Excessive alcohol or drug use, or advice to limit, cease or receive counseling for alcohol or drug use		
	X	9. Disease or disorder resulting in rejection, higher premiums, or reduction in insurance by any insurance company		
	X	10. Acquired immune deficiency syndrome (AIDS), AIDS Related Complex (ARC) or AIDS-related conditions		
	X	11. In the last five years, peptic ulcer, jaundice, gall stones, chronic diarrhea or any digestive or intestinal disorder		
	X	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		
	X	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		
	X	14. Requested or received a pension, benefits or payment because of an injury, sickness or disability		
	X	15. In the last 12 months, ANY use of nicotine delivery products (cigarette, e-cigarette, cigar, pipe, snuff, vaping, chewing tobacco, gum, etc.)		
	X	16. In the next 12 months, scheduled or anticipate any surgical procedures		
	X	17. In the next 12 months, plan to travel to or reside in a foreign country		
	X	18. In the last or next 6 months, participated in 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)		
	X	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 at death.)		

Provide explanations f r "YES" answers here.

APPLICANT 1	APPLICANT 2
Refer Medical Report attached	

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

4. PAYMENT SELECTION

Payment Type	Required Deposit
☐ Military allotment monthly	2 months
☐ Checking account monthly *(EZPay)**	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.**

**** Use attached form.**

Applications cannot be processed without a deposit.

Account Holder/Payer Name

Account Holder Mailing Address

ABA Routing Number *(for EZPay only if no voided check)*

Account Number *(for EZPay only if no voided check)*

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 or by mail by calling 1-877-398-2263.

APPLICANT 1		APPLICANT 2	
Insured Printed Name *(First MI Last)* Julie Smart		Insured Printed Name *(First MI Last)*	
Insured Signature *(Parent if under age 18)*	Date *(mm/dd/yyyy)*	Insured Signature *(Parent if under age 18)*	Date *(mm/dd/yyyy)*

To designate someone other than the Insured as Owner, complete this section.

Owner Name *(Last, First MI)*	Social Security Number	Owner Name *(Last, First MI)*	Social Security Number
Mailing Address	Relationship to Insured	Mailing Address	Relationship to Insured
E-Mail (☐ *Personal* ☐ *Work)*	Phone (☐ *Cell* ☐ *Home* ☐ *Work)*	E-Mail (☐ *Personal* ☐ *Work)*	Phone (☐ *Cell* ☐ *Home* ☐ *Work)*
Owner Signature	Date *(mm/dd/yyyy)*	Owner Signature	Date *(mm/dd/yyyy)*

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 ☐ Accept ☐ Withdraw ☐ Defer		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

Application Addendum

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

Refer Medical Report attached

SIGNATURE. All statements and answers are true to the best of my knowledge.	
Insured Name *(Last, First MI)* Julie Smart	Insured Social Security Number 575-45-6789
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. MEMBER INFORMATION

Premier Services (Member only) - Expand the benefits of your AAFMAA membership with additional services designed specifically to meet the needs of military and veteran families for only $5.95 per month. See www.aafmaa.com or contact AAFMAA for more details. Available for non-grandfathered members only.

Applicants - You may apply for two policies by completing the sections designated for Applicant 1 and 2.

2. INSURANCE COVERAGE

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.

Beneficiary Designation - 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.

3. MEDICAL INFORMATION

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

4. PAYMENT SELECTION

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 your 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*** - Use attached form. **Credit card will be charged when policy is issued.**

5. AUTHORIZATION

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.

Application Medical Requirements

AAFMAA
COMPASSION • TRUST • PROTECTION

Applicants must accurately and completely answer ALL medical questions on the application. Failure to provide accurate, complete responses will invalidate the insurance coverage. **Provide explanations for "yes" answers.** Based on underwriting review, additional information may be requested.

Please submit the following requirements:

Applying for Level Term I:	Applying for $400,000 or less: Requirement A. Applying for over $400,000: Requirement B or C.

Applying for Level Term II or Five-Year Renewable Term and:	
Active Duty or **Full-Time Guard/Reserve**	Requirement B.
Part Time Guard/Reserve, Retired, Veteran, Spouse or Child (age 18-23)	Requirement C.

Applying for Value-Added Whole Life and:	
Active Duty or Full Time Guard/Reserve • Under age 40 AND • "No" for medical questions Section 3	Applying for $400,000 or less: Requirement A. Applying for over $400,000: Requirement B.
Active Duty or Full Time Guard/Reserve • Over age 39 OR • "Yes" for medical questions Section 3	Requirement B.
Spouse • Under age 40 AND • "No" for medical questions Section 3	Applying for $400,000 or less: Requirement A.
Part Time Guard/Reserve, Retired, Veteran or all other Spouses	Requirement C.
Child or Grandchild (Age 6 months - 23 years)	Applying for $100,000 or less: Requirement A. Applying for over $100,000: Requirement D.

REQUIREMENTS	
A. **No medical records** are required to be sent with application. However, AAFMAA may subsequently request medical information.	**B. Full Time Active Duty** Most recent copy of your military exam completed in the **last 2 years** to include: • Medical exam with **blood/urine tests*** • Medical history • Age 50+ - PSA test (males) / Age 55+ - EKG test If you cannot provide required medical information, please contact AAFMAA to request an exam at our expense.
C. Not Full Time Active Duty - Adults Examinations are provided free by AAFMAA and are scheduled at your convenience. Examinations consist of a medical review with blood and urine, plus EKG for age 55+.	**D. Children** • Age 6 months - 6 yrs: Well baby statement • Age 7-14 yrs: Routine/school physical within 12 months • Age 15-23 yrs: Requirement C

* **REQUIRED LAB:** **Blood Chemistry:** **HIV**, Glucose, BUN, Alk Phos, AST (SGOT), ALT (SGPT), GGT, Triglycerides, Cholesterol, HDL Chol, Chol/HDL Ratio, LDL.

Urinalysis: Protein, Glucose.

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

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 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. 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 application 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.