Simple Term 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
Span, One			Capt. - O3	XXX-XX-5656
Email (☒ *Personal* ☐ *Work*)			Gender	Birth Date *(mm/dd/yyyy)*
ngorbatovskikh@aafmaa.com			☒ Male ☐ Female	12/12/1967
Street			Phone (☐ *Cell* ☒ *Home* ☐ *Work*)	
123 Old reston ave			571-123-1234	
City	State	Zip	Phone (☐ *Cell* ☐ *Home* ☐ *Work*)	
Reston	VA	20190		

Insured is applying as *(select one)*	Member Name *(if not the Insured)*	Member SSN *(if not the Insured)*
☒ Member ☐ Spouse ☐ Child ☐ Grandchild		

Military Status	Military Service
☒ Active ☐ Guard ☐ Reserve ☐ Retired ☐ Veteran	☐ Army ☒ Air Force ☐ Navy ☐ Marines ☐ Coast Guard

2. INSURANCE COVERAGE.

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

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
***Attach blank check marked "VOID" - not deposit slip.**	
☒ ☐ Credit card monthly	1 month
☐ Bill quarterly	3 months
☐ Bill semiannually	6 months

Account Holder/Payer Name: hh dd

Account Holder Mailing Address: 123 Old reston ave, Reston, VA 20190

Bank Account Number OR Credit Card Number: X X X X X X X X X X X X 1 1 1 1

Bank ABA Routing Number OR Credit Card Expiration Date: 1 0 / 2 0 2 4

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
Estate			
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 INFORMATION

1. Name *(Last, First MI)*	Height *(feet/inches)*	Weight *(pounds)*	Last physical exam date
Span, One	5'5"	123 lbs	10/01/2024

	YES	NO
2. 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?		X
3. In the past 2 years, have you been admitted to a hospital, psychiatric or rehabilitation center, nursing home, extended care or special treatment facility?		X
4. In the past 3 months, have you consulted a doctor or health care professional, had treatment or any diagnostic health tests?		X

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.

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)*
	One Span	

Drivers License Number *(☒ Not a licensed driver)*	State of Issue *(Two letter)*

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).*

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)* Span, One	Insured Social Security Number XXX-XX-5656
Insured Signature *(parent/guardian signature if Insured is under age 18)*	Date Signed *(mm/dd/yyyy)* / /

Supplementary Information

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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. Review the insurance you are applying for and your answers to the medical questions.
3. Request any required medical from you to prove your insurability.
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. Withdraw or postpone the application based on our underwriting review. AAFMAA will notify you in writing if it must take this action.
   c. Contact you if there is another AAFMAA policy that you may be eligible for.
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.