9800 Fredericksburg Road
San Antonio, Texas 78288

Term Life Insurance Application

0009

Step 1. Verify and complete the following information. Make changes to incorrect information directly on this application. Initial each change.

Step 2. Return completed and signed application to USAA Life.

IMPORTANT INFORMATION. Federal law requires us to obtain, verify and record your name, address, date of birth and other information that will allow us to identify you when you open an account and in certain other circumstances.

Personal Information

A. Insured

030123620		**03 / 25 / 1976**
USAA Number	Social Security Number	Date of Birth (mm/dd/yyyy)

LOAN K ROBINSON

Name

1692 YALE ST	**CHULA VISTA CA 91913-2630**
Mailing Address	
1692 YALE ST	**CHULA VISTA, CA 91913-2630**
Physical/Residence Address	

loankimrobinson@gmail.com

Residence Phone Number (include area code) E-mail Address

RESEARCH SCIENTIST	$ **200,000**
Occupation	Annual Income

Branch of Service	Rank	Military Status
☒ Female ☐ Male	**E2997582**	
Gender State of Birth	Driver's License Number	State of Issue

Are you a U.S. citizen? ☒ Yes ☐ No

What is your total amount of life insurance protection, current and pending, excluding this application? **500,000**

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities?
☐ Yes ☒ No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

	☐ Annuity ☐ Life Insurance	$ Amount	Policy/ Contract Number
Company Name			
	☐ Annuity ☐ Life Insurance	$ Amount	Policy/ Contract Number
Company Name			

B. Owner

030123620		**03 / 25 / 1976**
USAA Number	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)

LOAN K ROBINSON	**SAME**
Name (If trust, provide name of trust and trustee.)	Relationship to Insured
1692 YALE ST	**CHULA VISTA CA 91913-2630**
Mailing Address	
1692 YALE ST	**CHULA VISTA, CA 91913-2630**
Physical/Residence Address	

loankimrobinson@gmail.com

Residence Phone Number (include area code) E-mail Address

Are you a U.S. citizen? ☒ Yes ☐ No

C. Payor

030123620		03 / 25 / 1976
USAA Number	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.)

LOAN K ROBINSON

Name (If trust, provide name of trust and trustee.)

1692 YALE ST	CHULA VISTA CA 91913-2630
Mailing Address	
1692 YALE ST	CHULA VISTA, CA 91913-2630
Physical/Residence Address	
	loankimrobinson@gmail.com
Residence Phone Number (include area code)	E-mail Address

Are you a U.S. citizen? ☒ Yes ☐ No

Product and Optional Coverages

A. Product

25 YEAR LEVEL TERM SERIES V	$ 1,000,000
Insurance Product Name	Insurance Amount

B. Optional Coverage

☐ Disability Waiver of Premium (age 55 or younger)

☐ Accidental Death Benefit (ADB) (age 60 or younger) $ NO LONGER OFFERED (Amount)

C. Child Protection Plan

$ _____ (Amount of Child Rider Insurance) (age 17 or younger)

Child's Name	Social Security Number	Date of Birth (mm/dd/yyyy)
		/ /

What is this child's total amount of life insurance protection, current and pending, excluding this application? $ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? ☐ Yes ☐ No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

☐ Annuity
☐ Life Insurance

Company Name	$ Amount	Policy/ Contract Number

Child's Name	Social Security Number	Date of Birth (mm/dd/yyyy)
		/ /

What is this child's total amount of life insurance protection, current and pending, excluding this application? $ _____

Is this application for insurance intended to replace, discontinue or change any life insurance or annuities? ☐ Yes ☐ No If yes, list details. (Attach an additional sheet of paper if more space is needed.)

☐ Annuity
☐ Life Insurance

Company Name	$ Amount	Policy/ Contract Number

Attach an additional sheet of paper if more than two children.

Beneficiary Information

Beneficiaries on Separate Page

Primary Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) / /	Relationship to Insured

Contingent Beneficiary Name (If trust, provide name of trust.)	Social Security Number (or Tax ID Number)	Date of Birth (mm/dd/yyyy) (If trust, provide date of inception.) / /	Relationship to Insured

Attach an additional sheet of paper if more space is needed.

Payment Information

A. Method

☒ Automatic Payment Plan (APP): $ **111.65**
(For APP, complete section C. Financial Information)

☐ Direct Billing: $ _____

☐ Monthly Government Allotment : $ _____

B. Frequency of Payment

☒ Monthly (not available with Direct Billing) ☐ Quarterly ☐ Semi-Annually ☐ Annually

C. Financial Information (Complete only if APP is selected.)

I authorize USAA Life Insurance Company to make electronic withdrawals and deposits to my account listed below until I notify USAA Life that I terminate authorization and USAA Life has reasonable time to act. I acknowledge that the origination of Automated Clearing House (ACH) transactions to my account must comply with U.S. law.

Specify a day between the 1st and 28th of the month for payment. **4** Day

Navy Federal Credit Union	**Loan Robinson**	☒ Checking ☐ Savings
Name of Financial Institution	Name(s) of Account Holder	Type of Account

256074974	**7134256135**
Transit Routing Number (the nine-digit number in the lower-left corner of check or deposit slip)	Account Number

x _____
Signature of Account Holder Date (mm/dd/yyyy)

Additional Information

Provide any additional information or details you want considered below.

Read and Sign

Effective Date of Coverage: I agree that, except as provided in the company's Temporary Insurance Agreement, no insurance coverage will take effect prior to delivery of the policy to the Owner and then only if all of the following conditions have been met:

(1) the health and insurability of each person is as stated in this application and in additional parts (if applicable), and the company is immediately notified in writing of any changes; and

(2) the company has received the first full premium payment while each person is alive.

If the above conditions have been met, coverage under the policy will be effective on the date the policy is delivered to the Owner; provided however, that if a later effective date has been requested, coverage under the policy will be effective on that later date. I understand that any insurance coverage issued will be subject to the suicide and incontestability provisions of the policy. These provisions begin on the effective date.

Insurance Fraud Warning

Arkansas, Louisiana, New Mexico, Ohio, Rhode Island, West Virginia:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia, Maine, Tennessee, Washington:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky, Pennsylvania:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

New Jersey:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma:

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Authorization: I understand the information obtained by use of this Authorization will be used by USAA Life to determine my eligibility for life insurance. I understand that information released pursuant to this Authorization may no longer be protected by federal privacy regulations and could be subject to redisclosure. I understand that although this authorization is voluntary, USAA Life reserves the right to decline to issue the insurance applied for if I refuse to grant this authorization.

I authorize the following persons and organizations to provide information to USAA Life Insurance Company ("USAA Life"): (a) any licensed physician; (b) any medical practitioner; (c) any hospital; (d) any insurance company; (e) any clinic, Veteran's Administration clinic, or medically-related facility; (f) Medical Information Bureau (MIB); (g) any psychiatrist or psychologist; (h) any health facility; (i) any consumer reporting agency.

For purposes of this Authorization, "information" means any records or knowledge concerning any insured's health or mental condition, general character and driving record.

This includes the release of the entire medical record of any Insured including all information about AIDS, HIV, drugs, alcoholism, or mental illness. This Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164.522.

I further authorize a consumer reporting agency to make an investigative report on me if it is requested by USAA Life and expect to be interviewed if a report is prepared.

I authorize the above listed sources to provide records or knowledge to any agency employed by USAA Life to collect and transmit such information. A reproduction of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for twenty-four (24) months from the date signed, and upon request I or my authorized representative can receive a copy of this Authorization. I understand that I may revoke this Authorization by sending a written request to USAA Life. A revocation does not affect any action taken by USAA Life in reliance on the authorization prior to the revocation, nor does it have any effect on any right of contestability under the policy.

I have read and understand this authorization. I have received, read and understand the enclosed Notice of Privacy and Disclosure Practices.

Acknowledgment: I have read the questions and answers in this application. I represent that all statements and answers provided in this application and as part of the application process are true, complete and correctly recorded and will be relied upon by USAA Life Insurance Company to form the basis of any policy which may be issued. I agree that a copy of this application, if approved, will be a part of any policy issued. I understand I may not receive an illustration until the policy is issued.

Loan K Robinson

Printed Name of Insured

This electronic signature fully complies with the Federal Electronic Signature statute, Title 15, U.S.C., Chap. 96, Sec. 7001, et. seq., and is therefore fully legal and valid as an original signature.

X

Signature of Insured | Date (mm/dd/yyyy) | City | State

X

Signature of Owner (if different than Insured) | Date (mm/dd/yyyy)

X

Signature of Custodial Parent of Child (if Child Protection Plan selected) | Date (mm/dd/yyyy)

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