

# Life Insurance Application

An instruction sheet is attached to assist you in completing this application.  
Please review the application upon completion to ensure all required information has been provided.



## 1. Military Member's Information (Must be completed on the military member)

Name (First, Middle, Last, Suffix)

Rank

Service  USN  USMC  USCG  USPHS  NOAA

Status  Active Duty  Retired  Reserve  Veteran

Current NMAA Member  Yes  No

Date of Birth (mm/dd/yyyy)

Gender  Male  Female

Nicotine Use\* within past 12 mos.  Yes  No

Date Retired / Separated (mm/dd/yyyy)

Social Security Number

Address (Street, Apartment)

Address (City, State, Zip Code)

Email Address

Home Phone

Work/Cell Phone

## 2. Proposed Insured's Information

2a. Please complete the below information on the proposed insured

Insured's Relationship to Military Member  Member (Self)  Spouse  Child  Grandchild

2b. Complete this section only if the proposed insured is the spouse, child, or grandchild.

Name (First, Middle, Last, Suffix)

Date of Birth (mm/dd/yyyy)

Gender  Male  Female

Nicotine Use\* within past 12 mos.  Yes  No

Social Security Number

Address (Street, Apartment)

Address (City, Zip Code)

Email Address

Home Phone

Work/Cell Phone

*\*You are classified as a nicotine user if you have used any form of tobacco or nicotine product in the past 12 months.*

## 3. Proposed Owner's Information

(Please complete only if the military member stated above will NOT be the owner of this life insurance plan)

Name (First, Middle, Last, Suffix)

Date of Birth (mm/dd/yyyy)

Gender  Male  Female

Social Security Number / TIN

Address (Street, Apartment)

Address (City, Zip Code)

Email Address

Home Phone

Work/Cell Phone

## 4. Insurance Coverage Information (Please see premium quote sheet and brochure for premium details)

Coverage Effective Date (mm/dd/yyyy)

Insured's Age on Coverage Effective Date

Total Navy Mutual coverage on a Member or spouse cannot exceed \$1,000,000. Children and grandchildren cannot exceed \$250,000 of Permanent 'Plus'.

Is this application intended to replace an existing Navy Mutual plan?  Yes  No If "Yes", please enter the plan number to be terminated:

### Type Of Life Insurance Desired—Select Only One

<input type="checkbox"/> Flex Term	Coverage Amount \$	Monthly Premium \$	
<input type="checkbox"/> Level II 'Plus' Term to age _____	Coverage Amount \$	Monthly Premium \$	
<input type="checkbox"/> Permanent 'Plus' with premiums payable for _____ years. If electing a <i>single premium</i> , check this box <input type="checkbox"/> and enter the single premium amount in the "Monthly Premium" field.	Coverage Amount \$	Lump Sum Premium \$	Monthly Premium \$

**Only complete information below if proposed insured in section 2 is a child or grandchild.** In the event the owner of the above elected Permanent 'Plus' plan dies and the insured is a child or grandchild, the following person is designated as the successor-owner of this benefit plan.

First Name	MI	Last Name	Social Security Number	Relationship to Insured
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## 5. Rider Coverage Information

### Choose the Desired Rider Coverage

<input type="checkbox"/> Extended Convertability Rider Only available with Level II 'Plus' Term	Coverage Amount \$	Monthly Premium \$
<input type="checkbox"/> Family Benefit Rider	Units of Coverage	Monthly Premium \$

### Insured's Information for the Family Benefit Rider (Do not complete if you did not elect the Family Benefit Rider Coverage)

Please attach a separate sheet containing additional children if necessary.

Spouse's Full Name	Has spouse used nicotine products within past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number	Date of Birth (mm/dd/yyyy)
Child' Full Name	Relationship to Insured	Social Security Number	Date of Birth (mm/dd/yyyy)
Child' Full Name	Relationship to Insured	Social Security Number	Date of Birth (mm/dd/yyyy)

## 6. Premium Payment Information

**Total Monthly Premium** Enter the sum of premiums located within Section 4 "Insurance Coverage Information" and Section 5 "Rider Coverage Information". Total Monthly Premium \$

**Required Initial Deposit Payment:** Please enclose a check for 3 months of the "Total Monthly Premium" stated above. If a Permanent 'Plus' plan is being applied for and is being paid for with a single premium, please enclose a check for 2% of the Single Premium. Make check payable to NMAA. Deposit Payment Enclosed \$

### Future Premium Payment Method Select Only ONE Payment Method Below

Military Allotment (Please contact your disbursement office to start or increase your military allotment to NMAA)

#### Automated Bank Draft

Please use enclosed "Required Initial Deposit Payment" check for purposes of deducting future premium payments

**-OR-**

Please use enclosed Voided check for purposes of deducting future premium payments

Frequency of Deductions:  Monthly  Quarterly *Deductions will occur on or about the 15th of the month.*

Direct Billing Bill Me:  Quarterly  Semiannually  Annually



## 8. Beneficiary Information In the event of the insured's death, the benefit under this application will be paid to:

### PRINCIPAL BENEFICIARY(IES)

Full Name Gender  Male  Female

SSN Relationship to Insured DOB % of death benefit to be received

Address

Full Name Gender  Male  Female

SSN Relationship to Insured DOB % of death benefit to be received

Address

**If there is no living Principal Beneficiary, the benefit under this application will then be paid to:**

### CONTINGENT BENEFICIARY(IES)

Full Name Gender  Male  Female

SSN Relationship to Insured DOB % of death benefit to be received

Address

Full Name Gender  Male  Female

SSN Relationship to Insured DOB % of death benefit to be received

Address

**OR**  All living children born or adopted of the insured shall share and share alike.

If you require additional space to provide more than two Principal and/or Contingent beneficiaries, please attach a separate sheet stating the type of beneficiary (i.e., Principal or Contingent), along with all the requested information stated above. **Initial here if attaching sheet**

**PLEASE NOTE:** If no beneficiary is listed above or if at the time of the annuitant's death the named beneficiaries is/are not living, the death benefit shall be paid to: the insured's lawful spouse at the time of death; then to all children born or adopted by the insured; then to the natural mother and father of the insured; then to the estate of the insured.

## 9. Authorization, Disclosure and Certification

I hereby agree to conform to the Bylaws of the Navy Mutual Aid Association and understand that membership eligibility and medical approval are conditions precedent to insurability, that Family Benefit Rider coverage terminates upon my death or surrender of my death benefit plan. I understand that death by suicide within two years of the effective date of this benefit plan negates the death benefit and will result in return of premiums to the owner.

Subsidized life insurance in amounts up to \$400,000 is available at a cost of \$3.25 per month per \$50,000 of coverage to members of the Armed Forces from the Federal Government through the Servicemembers' Group Life Insurance ("SGLI") program under subchapter III of chapter 19 of title 38, United States Code. This Navy Mutual product is not offered or provided by the Federal Government, and the Federal Government has not in any way sanctioned, recommended or encouraged its sale. Permanent 'Plus' contains a standard Automatic Premium Loan ("APL") provision under which, if Navy Mutual does not receive a scheduled premium payment within thirty days after the premium due date, a loan will be established against the cash value of the policy to pay the premium. If the policy is paid out through death or surrender before the loan is repaid, the total outstanding loan balance (which includes both the outstanding principal and interest) will be deducted from the death benefit or surrender value respectively. No person has received a referral fee or incentive compensation in connection with the offer or sale of this individual product; however, Navy Mutual's sales representatives participate in a department-wide bonus program that is based on their collective achievement of monthly departmental goals. For purchases outside the United States, consumer complaints regarding this product can be submitted to the Virginia State Corporation Commission Bureau of Insurance, P.O. Box 1157, Richmond, Virginia 23218, telephone number (804) 371-9741.

I authorize the Association to have access to any medical information contained in my official records including database files containing viral/infectious disease information, such as hepatitis, human immunodeficiency virus (HIV), etc. Further, I authorize medical practitioners/facilities and any government agency to furnish any such information the Association may request, including my military and civilian address, with the understanding a photostatic copy of this authorization will be as valid as the original.

**BY THE SIGNATURE(s) below I(we) do attest that the statements and answers in all parts of this application are complete and true and will be the basis for any insurance issued.**

Signature of Military Member Date Signed (mm/dd/yyyy)

Signature of Owner (If different from the Member) Date Signed (mm/dd/yyyy)

Signature of Insured under Section 2B if different from the Member (If insured is a minor, signature of parent or guardian) Date Signed (mm/dd/yyyy)

Signature of Spouse under Section 5 (Only required if Family Benefit Rider coverage is elected for spouse) Date Signed (mm/dd/yyyy)

**Please mail your completed application (to include medical forms) and your check or money order to:  
Navy Mutual Aid Association, Henderson Hall, 29 Carpenter Road, Arlington, VA 22212**

Applications and medical forms may also be faxed to 703-945-1441  
Call Toll Free 800-628-6011 ■ E-mail: [counselor@navymutual.org](mailto:counselor@navymutual.org) ■ Website: [www.navymutual.org](http://www.navymutual.org)

# Instruction and Explanation Sheet

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## 1. Military Member Information

Please enter all the requested personal information on the **military member**.

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## 2. Proposed Insured's Information

Please enter the requested personal information on the **insured**. If the proposed insured is the military member shown in section 1, only complete section 2A. If the proposed insured is the spouse, child, or grandchild, please complete sections 2A and 2B.

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## 3. Proposed Owner's Information

If the owner of this life insurance plan is not the military member in Section 1, please complete all requested information.

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## 4. Insurance Coverage Information

Enter the date you would like your coverage to begin into the "Coverage Effective Date (mm/dd/yyyy)" field.

Enter the age of the Proposed Insured as of the coverage effective date in the "Insured's Age on Coverage Effective Date" field.

Indicate if you intend to replace an existing Navy Mutual policy with this application. If yes, enter the policy number(s) you want to terminate upon activation of this new policy. Please be aware that total face amount of Navy Mutual coverage on a Member or spouse cannot exceed \$1,000,000. Children & grandchildren cannot exceed \$250,000.

Check the box next to the plan you would like to purchase. **Only one plan may be elected per application.**

The monthly premium can be determined from the quote sheet provided with your brochure and application. Otherwise, you may obtain the monthly premium by calling a membership representative at 800-628-6011 or going to Navy Mutual's website at [www.navymutual.org](http://www.navymutual.org).

For **Flex Term**: Enter the coverage amount desired.

A minimum of \$50,000 is required and additional coverage is available in \$10,000 increments.

Enter the monthly premium for the desired coverage.

For **Level II 'Plus' Term**: Indicate the desired age you would like the coverage to terminate. Maximum termination age is 85.

Enter the coverage amount desired.

A minimum of \$50,000 is required and additional coverage is available in \$10,000 increments.

Enter the monthly premium for the desired coverage and term duration.

For **Permanent 'Plus'**: Enter the number of years you want to pay premiums.

Enter the coverage amount desired.

A minimum of \$20,000 is required and additional coverage is available in \$10,000 increments.

Enter the lump sum premium you intend to pay in addition to future monthly premiums.

Enter the monthly premium for the desired coverage. If you are paying the plan with a Single Premium payment, check the box located in the first field of the row and enter the single premium amount in the "Monthly Premium" field.

If a Permanent 'Plus' plan is being purchased and the Proposed Insured in Section 2 is a child or grandchild of the military member, please enter the name of the desired successor-owner of the policy if the owner of the plan dies. Do not complete the successor-owner information if the insured of the Permanent 'Plus' plan is the member or spouse.

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## 5. Rider Coverage Information

Choose the desired Rider Coverage you would like to add to the life insurance plan you elected in Section 4.

**Extended Convertibility Rider:** This rider is only available if you choose Level II 'Plus' in Section 4. This rider allows the Level II 'Plus' Term coverage to be transferred at a future date to a Permanent 'Plus' life insurance plan without a physical. You may enter into the "Coverage Amount" field a minimum of \$20,000 or an amount up to 100% of the value entered in Section 4. Coverage may be chosen in \$10,000 increments.

**Family Benefit Rider (FBR):** This rider allows coverage to be purchased on the spouse and children of the insured elected in Section 4. FBR coverage is sold in units. 1 FBR unit is available for each \$50,000 of Flex Term or Level II 'Plus' Term coverage elected and 1 FBR unit per \$20,000 of Permanent 'Plus' coverage elected. No more than 4 FBR units may be purchased per military member. The monthly premium per unit is \$1.00 for non-nicotine users and \$1.30 for nicotine users.

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## 6. Premium Payment Information

Enter the **Total Monthly Premium** in the first field of this section. The total monthly premium is the sum of the premiums located within the "Insurance Coverage Information" and "Rider Coverage Information" sections. The premium you have been provided is a quote only, your actual premium will be determined by an underwriting review of your health and lifestyle.

**Deposit Payment Enclosed:** Please enter the amount of the deposit payment you are enclosing with your application. Checks can be made to NMAA and enclosed with the application.

**Future Premium Payment Method:** You may only select one premium payment method from the three available options.

**Military Allotment:** Deductions may be made on a monthly basis from your military pay. You must contact your disbursement office to start or increase your military allotment to NMAA.

**Automated Bank Draft:** Electronic deductions will be made from your bank account automatically on or near the 15th of each month. In addition, please check one of the two boxes indicating the frequency of your deductions.

**Direct Billing:** You may choose to receive a bill Quarterly, or Semiannually, or Annually

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## 7. Medical Information

If answering "yes" to any of the medical questions (except tobacco use), please provide the details in the space provided below section 7. Give name of family member, nature of illness, number of attacks, duration, dates, names and addresses of attending physicians. Also list prescription medications used by you and your family within last five years for other than minor illnesses.

**Medical Information Is Required:** The following proof of insurability will be required, if not available a medical examination will be arranged and conducted by the Association's paramedical/physician service and paid for by NMAA.

### Active Duty Insured

Complete the Medical Questionnaire, attach a copy of your most recent military physical, Report Of Medical Examination (SF-88 or SF-2808) and Report of Medical History (SF-93 or SF-2807) or NAVMED 6120/2 if available. Include all ancillary tests completed (blood chemistry, urinalysis, etc.).

### Non-Active Duty Insured and/or Spouse

Complete the Medical Questionnaire. We can accept a physical from a personal physician, if it is less than one year old. Attach a copy and include all ancillary blood and urine tests that may have been done. These tests should include: Cholesterol, HDL Cholesterol, Triglycerides, Fasting Blood Glucose, HIV, and a urinalysis. Also, PSA testing is required for males aged 45 and above.

### Children or Grandchildren under Permanent 'Plus' Policies

NMAA requires evidence of insurability in order to provide coverage at the lowest cost. The parent or legal guardian of the Insured, or the Insured if majority age for state of domicile has been attained, must complete the medical questionnaire and sign in the indicated space at the bottom of this form. Additional proof of insurability is required as follows:

**Age 6 months through 17 yrs:** Attach a current Physicians Statement or most recent school physical within the past year.

**Age 18 through 23 yrs:** Blood and urine sample analyses that will be arranged and paid for by us. If Proposed Insured's date of last physical examination is within past six months, please provide copy.

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## 8. Beneficiary Information:

Enter information on the desired Principal Beneficiary(ies) (i.e., the first person(s) designated to receive the insurance proceeds) and Contingent Beneficiary(ies) (i.e., the person(s) designated to receive the insurance proceeds if the Principal Beneficiary is not alive at the time of the insured's death). In the event you desire to have all living children born or adopted of this marriage receive the insurance proceeds equally as contingent beneficiaries, please check the boxes located under the Contingent Beneficiary designation area.