

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)

Status Active Duty Retired Reserve Separated Veteran

Service USN USMC USCG USPHS NOAA

Rank

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

Check here if to be owned by a trust

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:

If replacing a Family Plan, will both Member and spouse coverage be terminated? Yes No

Type Of Life Insurance Desired—Select Only One

Flex Term Coverage Amount Monthly Premium
\$ \$

Level II 'Plus' Term to age _____ Coverage Amount Monthly Premium
\$ \$

Permanent 'Plus' with premiums payable for _____ years. Coverage Amount Lump Sum Premium Monthly Premium
If electing a *single premium*, check this box and enter the \$ \$ \$
single premium amount in the "Monthly Premium" field.

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 |
|------------|----|-----------|------------------------|-------------------------|
|------------|----|-----------|------------------------|-------------------------|

5. Rider Coverage Information

Choose the Desired Rider Coverage

Extended Convertability Rider Coverage Amount Monthly Premium
Only available with Level II 'Plus' Term \$ \$

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's Full Name | Relationship to Insured | Social Security Number | Date of Birth (mm/dd/yyyy) |
|---|-------------------------|------------------------|----------------------------|
| Nicotine product used within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| Child's Full Name | Relationship to Insured | Social Security Number | Date of Birth (mm/dd/yyyy) |
|---|-------------------------|------------------------|----------------------------|
| Nicotine product used within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

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 1 month 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 Navy Mutual. 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 Navy Mutual)

Electronic Funds Transfer

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

CONDITIONAL COVERAGE

If a report of medical examination is required but not readily available, upon receipt of your "Required Initial Deposit Payment", the insurance coverage will be effective conditionally from the date of receipt of your application or the effective date you have specified, whichever date is later. If any conditionally insured is determined to have been uninsurable as of the date of the application, the death benefit will not apply and any premium paid will be refunded. Conditional coverage cannot exceed \$1,000,000, alone or in combination with any existing Navy Mutual coverage.

7. Medical Information Please complete the medical questions below

Insured's Height (in.) _____ Insured's Weight (lbs) _____ Please Check One: I am submitting a copy of the insured's most recent physical
 Please have Navy Mutual schedule a medical exam for the insured

| | Has the insured (and spouse/children if Family Benefit Rider is desired) ever had or been treated for any of the following? | Insured In Section 2 | | Spouse In Section 5 | | Children | |
|---|---|----------------------|----|---------------------|----|----------|----|
| | | Yes | No | Yes | No | Yes | No |
| 1. | High blood pressure, shortness of breath, chest pain, heart attack, stroke; palpitations, heart murmur; anemia or any disease of the blood, blood vessels, or heart | | | | | | |
| 2. | Tuberculosis, asthma, emphysema, bronchitis, pleurisy, or any disorder of the lungs; disorder of the thyroid or other glands | | | | | | |
| 3. | Convulsions, epilepsy, stroke, loss of consciousness, paralysis, dementia, brain disorder, nervous disorder, or mental health disorder | | | | | | |
| 4. | Diabetes; albumin, sugar, pus, or blood in urine; any disease/disorder of the kidneys, bladder or prostate | | | | | | |
| 5. | Hepatitis, ulcer, jaundice, gall stones, chronic diarrhea, or any digestive or intestinal disorder | | | | | | |
| 6. | Growth, tumor, malignancy or cancer; disease of the skin, bones or joints; arthritis or rheumatism | | | | | | |
| 7. | Any illness or injury (other than minor colds or flu) for which a physician or other practitioner was consulted; disease or physical deformity; or surgical procedure or hospitalization | | | | | | |
| 8. | Alcoholism, excessive use of alcohol; use of cocaine, barbiturates, amphetamines or any other habit forming drugs except as prescribed by a licensed physician | | | | | | |
| 9. | Any disease or disorder resulting in rejection, higher premiums, or a reduction in insurance by another insurer | | | | | | |
| 10. | Any medications taken within the past year (prescription, over the counter, herbal). List below with dosages, dates, and diagnosis/reason taken | | | | | | |
| 11. | Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions | | | | | | |
| 12. | Tested positive for HIV (AIDS) antibodies (unless prohibited by law) | | | | | | |
| 13. | Any use of cigarettes or other tobacco/nicotine products within the past year (i.e., cigars, chewing tobacco, nicotine patch/gum, or other nicotine delivery system) | | | | | | |
| PROPOSED INSURED'S LIFESTYLE QUESTIONNAIRE: Please answer questions below ONLY if applying for Level II 'Plus' Coverage. | | | | | | | |
| 14. | Have you in the past 5 years flown, or do you intend to fly, other than as a passenger? | | | | | | |
| 15. | Have you in the past 2 years, or do you intend to engage in, any hazardous activities or sports such as hang gliding, hot-air ballooning, ultra-light flying, mountain or rock climbing, motor vehicle racing, or scuba or sky diving? | | | | | | |
| 16. | Have you in the past 5 years traveled or resided, or do you intend to, outside the continental US for more than 4 consecutive weeks? | | | | | | |
| 17. | Have you ever been convicted of a misdemeanor (other than minor traffic violation) or a felony? | | | | | | |
| 18. | In the past 5 years, have you had your driver's license suspended or had 2 or more moving violations or accidents? | | | | | | |
| 19. | Have you been advised to seek, or received treatment for drug use, or been arrested for drug use or distribution? | | | | | | |
| 20. | Have you been counseled, sought help or treatment, or been advised to undergo counseling or treatment for alcohol problems? | | | | | | |
| 21. | Have you been advised to limit or cease the use of alcoholic beverages? | | | | | | |
| 22. | Has any proposed insured's immediate family member (parent, brother, or sister) had heart disease, diabetes, cancer, polycystic kidney disease or other familial disease at age 65 or younger? If yes, please provide relationship, disease or illness, whether living or deceased and current age or age at death. | | | | | | |

If any of the above questions are checked yes (except tobacco use), please provide the details on the lines below. Give name of family member, nature of illness, number of attacks, duration, dates, and 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. NOTE: After a review of your application and examination results, further explanation of medical information may be requested; to include the possibility of a new examination.

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 insured'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 ■ Website: www.navymutual.org

Instruction and Explanation Sheet

1. Military Member Information

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

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.

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. If this benefit plan is to be owned by a trust please attach a separate sheet and provide the following information: Name and Address of the Trust, Date of the Trust, Tax ID # of the Trust, and Name of the Trustee.

4. Insurance Coverage Information

Enter the date you would like your coverage to begin into the "Coverage Effective Date (mm/dd/yyyy)" field. Please note: the date must be between the 1st and the 28th day of the month.

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. If you are replacing a family plan, please indicate if both the Member and the spouse coverage is to be terminated.

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.

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.

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.

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 Navy Mutual 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 Navy Mutual.

Electronic Funds Transfer: 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

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 Documentation Is Required: Evidence of insurability documentation is required of all proposed insureds. You may provide either evidence of insurability from your personal medical records, or complete the exam requirements through the Association’s paramedical service, paid for by Navy Mutual Aid Association. If you provide evidence of insurability from your own medical records, the documentation must include the following components: a review of current medical problems, a comprehensive review of past medical history, blood pressure, measured height and weight, a routine urinalysis, and blood testing to include Cholesterol, HDL Cholesterol, Triglycerides, Fasting Blood Glucose, and HIV. Also, blood PSA testing is required for males age 45 and above. An electrocardiogram (ECG) tracing may be required for proposed insureds over the age of 45.

Active Duty Insured

Military forms that satisfy the above requirements are the ‘**Report of Medical Examination**’ (SF-88 or SF-2808) and ‘**Report of Medical History**’ (SF-93 or SF-2807) or NAVMED 6120/2. If submitting these forms, please verify that the above laboratory results are included on or with the forms. The documentation should be as recent as possible and cannot be older than 5 years.

Non-Active Duty Insured and/or Spouse

We can accept a physical from a personal physician, if it is less than one year old. The physical examination must include all of the above listed evidence of insurability components.

Children or Grandchildren under Permanent ‘Plus’ Policies

The parent or legal guardian of the proposed insured must sign the questionnaire. The proposed insured child must also sign if he or she has reached the age of majority in the state of domicile. 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: Physical measurements and blood and urine sample analyses that will be arranged and paid for by us. If the Proposed Insured’s date of last physical examination is within the past 12 months, please provide a copy.

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.