Application for a

CHILD BENEFIT RIDER

Use to add Child Coverage to an existing Navy Mutual Aid Association plan.

Provide coverage for a lifetime.

MONTHLY PREMIUM: $2.50 per month

One flat rate of $2.50 per month covers your current children at the time of application and any subsequent children born or adopted after the effective date of this Child Rider.

COVERAGE LIMITS: $10,000 per child

Level coverage of $10,000 applies to each unmarried, dependent child up to their 26th birthday.

ELIGIBILITY: Coverage is available for children beginning at 6 months of age and extending to children up to age 26. Coverage must be purchased prior to the child's 21st birthday.

CONVERTIBILITY: Coverage is convertible to $10,000 of Permanent 'Plus' which provides life-long coverage with tax-deferred cash value growth. Rider must be converted prior to the child's 24th birthday at the premium rate in effect at that time for the actual attained age of the child.

Navy Mutual

BENEFITS • INSURANCE • SINCE 1879

Henderson Hall ■ 29 Carpenter Road ■ Arlington, VA 22212
800-628-6011 ■ FAX:703-945-1441 ■ Website: www.navymutual.org ■ Email: counselor@navymutual.org

Application for **OPTIONAL CHILD BENEFIT COVERAGE** from Navy Mutual Aid Association

1. _____
Last Name First Name Middle Name

_____
Rank/Rate Date of Birth Social Security Number

I apply for Child Benefit Coverage providing $10,000 of level term coverage on eligible children to take effect on _____ .
Month / Day / Year

2. Address: _____
Street City State Zip

Telephone _____ Email _____

3. My monthly premium is $2.50 per month. ($2.50 per month covers your current children at the time of application and any subsequent children born or adopted after the effective date of this Child Rider.)

4. My membership certificate number to which this coverage is to be added is: _____

5. The person(s) proposed for insurance are:

FULL NAME (please print) First Middle Initial Last	SSN	Relationship	Date of Birth Month / Day / Year	Weight	Height

6. **MEDICAL QUESTIONNAIRE:** Has any proposed insured had or been treated for any of the following?	Children	
	Yes	**No**
a. 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		
b. Tuberculosis, asthma, emphysema, bronchitis, pleurisy, or any disorder of the lungs; disorder of the thyroid or other glands		
c. Convulsions, epilepsy, stroke, loss of consciousness, paralysis, dementia, brain disorder, nervous disorder, or mental health disorder		
d. Diabetes; albumin, sugar, pus, or blood in urine; any disease/disorder of the kidneys, bladder or prostate		
e. Hepatitis, ulcer, jaundice, gall stones, chronic diarrhea, or any digestive or intestinal disorder		
f. Growth, tumor, malignancy or cancer; disease of the skin, bones or joints; arthritis or rheumatism		
g. 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		
h. Alcoholism, excessive use of alcohol; use of cocaine, barbiturates, amphetamines or any other habit forming drugs, except as prescribed by a licensed physician		
i. Any disease or disorder resulting in rejection, higher premiums, or a reduction in insurance by another insurer		
j. Any medications taken within the past year (prescription, over the counter, herbal). List medications below with dosages, dates, and diagnosis/reasons for taking		
k. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions		
l. Tested positive for HIV (AIDS) antibodies (unless prohibited by law)		

If any of the above questions are checked yes, **please provide the details on a separate sheet of paper that is signed and dated**. Give name of family member, nature of illness, number of attacks, duration, dates and names and addresses of attending physicians. NOTE: After review of the application, further explanation of medical information may be requested, and could include the possibility of a request for medical records.

7. **DEPOSIT/PAYMENTS:** I have enclosed the REQUIRED deposit of $7.50 covering premiums for the next 3 months. Subsequent premiums for the Child Benefit Coverage will be added to my current method of payment for this plan. (I will increase my military allotment accordingly.)

8. **BENEFICIARY:** The beneficiary of this plan will be the owner of the plan to which this coverage is attached.

9. **AUTHORIZATION, DISCLOSURE AND CERTIFICATION:** I hereby agree to conform to the Bylaws of the Navy Mutual Aid Association. I understand that membership eligibility and medical approval are conditions precedent to insurability and that this Child Benefit Rider terminates upon my death, or upon 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.

BY THE SIGNATURE(s) below I 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. I(we) authorize the Association to have access to any medical information contained in our 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 our military and civilian address, with the understanding that a photostatic copy of this authorization will be as valid as the original.

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

Include check or money order with this application to:

Navy Mutual Aid Association, Henderson Hall, 29 Carpenter Road, Arlington, VA 22212

(800) 628-6011 ■ Fax: (703) 945-1441 ■ E-mail: counseloir@navymutual.org ■ Website: www.navymutual.org

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