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/Guard ☐ Separated Veteran

Service: ☐ USN ☐ USMC ☐ USCG ☐ USPHS ☐ NOAA ☐ USAF ☐ USA

Rank:

Current Navy Mutual Member? ☐ Yes ☐ No

Date of Birth: (mm/dd/yyyy)

Sex: ☐ Male ☐ Female

Nicotine Use:* within past 12 mos. ☐ Yes ☐ No

Date Retired / Separated: (mm/dd/yyyy)

Social Security Number:

Address: (Apt., Street, City, State, Zip Code)

Email Address:

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

Driver's License Number:

Driver's License State:

Doctor/Facility Name:

Doctor/Facility Phone:

Doctor/Facility Address:

Birth Country:

Birth State:

Occupation:

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)

Sex: ☐ Male ☐ Female

Nicotine Use:* within past 12 mos. ☐ Yes ☐ No

Social Security Number:

Address: (Apt., Street, City, State, Zip Code)

Email Address:

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 insurance plan)

Name: (First, Middle, Last, Suffix)

Date of Birth: (mm/dd/yyyy)

Sex: ☐ Male ☐ Female

Social Security Number / Tax Identification Number:

☐ **Check here if to be owned by a Trust**

Address: (Apt., Street, City, State, Zip Code)

Email Address:

Phone:

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

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	☐ Please check box if this is a 1035 Exchange.
1035 Exchange Amount:	1035 Exchange Company:
Do you wish to select conditional coverage? (see below)	☐ Yes, please provide the effective date (mm/dd/yyyy) _____ and the insured's age _____ on the effective date. ☐ No, your effective date will be when your application for life insurance is approved by underwriting (see section 7).

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 or ineligible for coverage 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.

Type Of Life Insurance Desired - Select Only One

☐ **Flex Term** Total coverage per insured cannot exceed $1,000,000.	Coverage Amount $	Monthly Premium $
☐ **Level II 'Plus' Term** to age _____ Total coverage per insured cannot exceed $1,000,000.	Coverage Amount $	Monthly Premium $
☐ **Flagship Whole Life** Select Plan Type: ☐ Single ☐ 10-Year ☐ 20-Year ☐ To Age 65 ☐ Life Initial Dividend Option: ☐ Purchase PUA (Paid Up Additions) ☐ Reduce Annual Premium Due ☐ Purchase OYT (One Year Term) ☐ Pay in Cash* Total coverage per insured cannot exceed $1,000,000.	Coverage Amount $	Monthly Premium $
		Illustration Reference #:

Only complete information below if proposed insured in section 2 is under 18 years old as of effective date of the contract. In the event the owner of the above elected Flagship Whole Life plan dies and insured is under 18 years old, the following person is designated as the successor-owner of this benefit plan. The successor-owner designated must be at least 18 years of age as of the effective date of the ownership change for the designation to be valid.

* If selecting the Cash Dividend Option, please provide bank account information in section 6 – Premium Payment Information.

First Name	MI	Last Name	Social Security Number	Relationship to Insured

5. Rider Coverage Information

Choose the Desired Rider Coverage

☐ **Extended Convertibility Rider:** Only Available with Level II 'Plus' Term	Coverage Amount $	Monthly Premium $
☐ **Child Benefit Rider:** Coverage to age 26	Coverage Amount $10,000	Monthly Premium $2.50
Paid-Up Addition Rider: PUA Rider is automatically included on all non-single premium FWL plans.	Initial PUA Premium $	Scheduled Premium $

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

Please attach a separate sheet containing additional children if necessary

Child's Full Name	Relationship to Insured	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)

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 Flagship Whole Life 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 set up your allotment – USA and USAF are not currently eligible for military allotment.)

☐ **Electronic Funds Transfer:**	Bank Name:	Routing #:	Account #:
	Frequency of Deductions: ☐ Monthly ☐ Quarterly		

☐ **Paper Bill:** Bill Me: ☐ Quarterly ☐ Semiannually ☐ Annually

The banking information above is used for EFT and the Cash Dividend Option. If EFT is selected along with the Cash Dividend Option, the same banking account will be used for both.

FOR NAVY MUTUAL USE ONLY Representative Name ID #

7. Medical Information Please complete the medical questions below

Insured's Height (in.)	Insured's Weight (lbs.)

Navy Mutual will schedule a medical exam for the insured if necessary. OR ☐ I am overseas and submitting required documents.

	Has the insured (and child/children if Child Benefit Rider is desired) ever had or been treated for any of the following?	Insured In Section 2		Children In Section 5	
		Yes	No	Yes	No
1.	Heart attack, chest pain, coronary artery disease, or any disease of the heart?	☐	☐	☐	☐
2.	High blood pressure, shortness of breath, or heart murmur?	☐	☐	☐	☐
3.	Anemia, or any disease of the blood or blood vessels?	☐	☐	☐	☐
4.	Tuberculosis, asthma, emphysema, bronchitis, pleurisy, or any disorder of the lungs; disorder of the thyroid or other glands?	☐	☐	☐	☐
5.	Convulsions, epilepsy, stroke, loss of consciousness, paralysis, dementia, brain disorder, nervous disorder, or mental health disorder?	☐	☐	☐	☐
6.	Albumin, sugar, pus, or blood in urine; any disease/disorder of the kidneys, bladder or prostate?	☐	☐	☐	☐
7.	Pre-diabetes or Diabetes?	☐	☐	☐	☐
8.	Hepatitis, ulcer, jaundice, gall stones, chronic diarrhea, or any digestive or intestinal disorder?	☐	☐	☐	☐
9.	Growth, tumor, malignancy or cancer; disease of the skin, bones or joints; arthritis or rheumatism?	☐	☐	☐	☐
10.	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?	☐	☐	☐	☐
11.	Alcoholism, excessive use of alcohol; use of cocaine, barbiturates, amphetamines or any other habit forming drugs except as prescribed by a licensed physician?	☐	☐	☐	☐
12.	Any disease or disorder resulting in rejection, higher premiums, or a reduction in insurance by another insurer?	☐	☐	☐	☐
13.	Any medications taken within the past five years (prescription, over the counter, herbal)?	☐	☐	☐	☐
14.	Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions?	☐	☐	☐	☐
15.	Tested positive for HIV (AIDS) antibodies (unless prohibited by law)?	☐	☐	☐	☐
16.	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)?	☐	☐	☐	☐
	Please answer the following questions only if you are applying for Level II 'Plus' or FWL coverage.				
17.	Have you in the past 5 years flown, or do you intend to fly, other than as a passenger?	☐	☐		
18.	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?	☐	☐		
19.	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?	☐	☐		
20.	Have you ever been convicted of a misdemeanor (other than minor traffic violation) or a felony?	☐	☐		
21.	In the past 5 years, have you had your driver's license suspended or had 2 or more moving violations or accidents?	☐	☐		
22.	Have you been advised to seek, or received treatment for drug use, or been arrested for drug use or distribution?	☐	☐		
23.	Have you been counseled, sought help or treatment, or been advised to undergo counseling or treatment for alcohol problems?	☐	☐		
24.	Have you been advised to limit or cease the use of alcoholic beverages?	☐	☐		
25.	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.	☐	☐		
26.	Do you reside in a nursing home or assisted living facility?	☐	☐		
27.	Do you require or receive assistance to perform any of the routine activities of daily living, including bathing, continence, dressing, eating, toileting, and transferring?	☐	☐		
28.	Do you require or receive assistance with ambulation (cane, walker, wheel chair, etc.)?	☐	☐		

If any of the above questions are checked yes, 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 the proposed insured/s within the last five years for other than minor illnesses. If needed, attach a separate sheet(s) of paper, signed and dated, with additional details. 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 or medical records.

_____

_____

_____

CERTIFICATION: By my signature below I do attest that the statements and answers above are complete and true.

_____

(Date) (Insured's Signature) (Insured's SSN) (Spouse's Signature, if applicable)

FOR NAVY MUTUAL USE ONLY Proc # _____

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:			**Sex:** ☐ Male ☐ Female
SSN:	**Relationship to Insured:**	**DOB:** (mm/dd/yyyy)	**% of death benefit to be received:**
Address:			
Email Address:		**Phone:**	
Full Name:			**Sex:** ☐ Male ☐ Female
SSN:	**Relationship to Insured:**	**DOB:** (mm/dd/yyyy)	**% of death benefit to be received:**
Address:			
Email Address:		**Phone:**	

If there is no living Principal Beneficiary, the benefit under this application will then be paid to: CONTINGENT BENEFICIARY(IES)

Full Name:			**Sex:** ☐ Male ☐ Female
SSN:	**Relationship to Insured:**	**DOB:** (mm/dd/yyyy)	**% of death benefit to be received:**
Address:			
Email Address:		**Phone:**	
Full Name:			**Sex:** ☐ Male ☐ Female
SSN:	**Relationship to Insured:**	**DOB:** (mm/dd/yyyy)	**% of death benefit to be received:**
Address:			
Email Address:		**Phone:**	

OR: ☐ All living children born or adopted of the insured shall share the same 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 there is no beneficiary surviving the death of an insured to whom benefits may be payable, the benefits are payable to the estate of the deceased insured.

9. Authorization, Disclosure and Certification

MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Navy Mutual Aid Association or its reinsurers 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 a claim for benefits is submitted to such a company, MIB, upon request, will supply such 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 866-692-6901. If you question the accuracy of 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 office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Navy Mutual Aid Association, or its reinsurers, 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.

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, and that any Child 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. Flagship Whole Life 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 hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to Navy Mutual Aid Association, or its reinsurers, any such information. Further, I authorize Navy Mutual Aid Association, or its reinsurers, to make a brief report of my protected health information to MIB. I understand, a photographic copy of this authorization will be as valid as the original.

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)

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

HIPAA-Compliant Authorization for Release of Medical Information

Henderson Hall • 29 Carpenter Road • Arlington, VA 22212
Phone: 800-628-6011 • Fax: 703-945-1441 • E-mail: counselor@navymutual.org • Website: www.navymutual.org

Name of Proposed Insured/Patient (please type or print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the Navy Mutual Aid Association. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the Navy Mutual Aid Association may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Navy Mutual Aid Association.

This authorization shall remain in force for 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that the Navy Mutual Aid Association has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the Navy Mutual Aid Association except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization, or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Navy Mutual Aid Association may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Proposed Insured/Patient or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Patient

FOR NAVY MUTUAL USE ONLY Proc # _____

Rev. 03/2016

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. In addition, please provide either a Certificate of Trust or a Full Trust Document. Please note that the proposed owner must be at least 18 years as of the effective contract date.

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 plan. If not indicated, only the proposed insured under this application portion of the family plan will be terminated upon activation of this new plan. Please be aware that total face amount of Navy Mutual coverage on a Member or spouse cannot exceed $1,000,000. If you are replacing a Family Plan, please indicate if both the Member and the spouse coverage is to be terminated.

If this application is for a 1035 Exchange please check the box, and enter amount and company. Please note that 1035 Exchanges are only available with Flagship Whole Life plans. For Single pay, 1035 will entirely apply to the base coverage. For any other plan types, 1035 will entirely apply towards the PUA Rider. Please visit navymutual.org to download the required 1035 Exchange Forms or contact us to send them to you.

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 **Flagship Whole Life**: Mark the checkbox for the desired plan type. Enter the coverage amount desired. A minimum of $10,000 is required and additional coverage is available in $10,000 increments.

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

Flagship Whole Life offers Dividend Options. Mark the checkbox for the desired Dividend Option (pick one). Please note that if the Pay in Cash Dividend option is selected, bank account information is required for payment processing. If Electronic Funds Transfer is selected in conjunction with the Cash Dividend Option, then the same banking account will be used for both.

If a Flagship Whole Life plan is being purchased and the proposed insured in Section 2 is under the age of 18, 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 Flagship Whole Life plan is the member or spouse. The successor-owner designated must be at least 18 years of age as of the effective date of the ownership change for the designation to be valid.

The following are base coverage limits based on age as of the effective date of the plan:

- Ages 00-03 | $10,000 - $250,000
- Ages 04-11 | $10,000 - $500,000
- Ages 12-17 | $10,000 - $750,000
- Ages 18-80 | $10,000 - $1,000,000

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 any currently offered permanent 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.

Child Benefit Rider (CBR): This rider allows coverage to be purchased on the children of the insured elected in Section 4. The Child Benefit Rider premium is a flat rate of $2.50 per month. This optional rider covers your current children at the time of this application and any subsequent children, born or adopted. Level coverage of $10,000 applies to each unmarried, dependent child up to their 26th birthday. This coverage is convertible prior to the child's 24th birthday to $10,000 of any currently offered permanent life insurance plan with tax-deferred cash value growth at the premium rates in effect for their attained age at the time of conversion.

Rev. 03/2016

Paid-Up Addition Rider: This optional rider allows the policy owner to increase the cash value and death benefit of the Flagship Whole Life plan over the base guarantees. Premiums paid into the Paid-up Additions Rider (PUAR) purchase Paid-up Additions (PUAs) which immediately increase the cash value and death benefit of the plan. PUAR premium may be fixed and scheduled with the base premium bill or paid as a separate flexible premium payment. Each PUAR premium payment must be at least $25. If a scheduled Paid-Up Addition Rider premium has been elected, the initial Paid-Up Addition Rider premium must be equal to or greater than the scheduled Paid-Up Addition Rider modal premium. Example: if Scheduled Annual Premium = $1,200 and billing frequency is monthly, then Initial PUAR premium must equal to at least $100.

PUA rider annual premium cap is 3x base annual standard (Nicotine Standard or Non-Nicotine Standard rate class even if regular premiums have a Select or Super Select designation, plus any substandard premium – table and/or flat) premium after the issue date with a lifetime face amount cap of $500,000, excluding any lump sum/1035 PUA premiums at issue. Premiums paid into the PUAR are subject to a front-end load. The PUAR will be canceled if no premium is received for 2 consecutive years from the last payment. The PUAR terminates when the base plan is paid-up or the insured has attained the age of 81, which ever happens first.

6. Premium Payment Information

Enter the **Total Monthly Premium** in the first field of this section. The Total Monthly Premium includes monthly base plus monthly scheduled PUA premium (if any) plus Child Benefit Rider (if any). 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 effective date of the contract each month.

Paper 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 individual, 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 is required of all proposed insureds. If further information is needed Navy Mutual Aid Association will schedule and pay for a medical exam through the Association's paramedical service.

Proposed Insureds Residing Outside of the United States

You may provide either evidence of insurability from your personal medical records or a completed Medical Requirements Certificate and HIPAA compliant authorization. These items are available from the Association's website at www.navymutual.org or by request to counselor@navymutual.org.

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 Overseas

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 Overseas

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 proposed insureds under any currently offered permanent life insurance plan

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: Evidence of insurability is required of all proposed insureds. If further information is needed Navy Mutual Aid Association will schedule and pay for a medical exam through the Association's paramedical service.

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 the insured receive the insurance proceeds equally as contingent beneficiaries, please check the boxes located under the Contingent Beneficiary designation area.