

## AFA VETERAN BENEFITS ASSOCIATION MULTI-BENEFIT ACCIDENT INSURANCE

Name \_\_\_\_\_ Rank \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth (mo/day/yr) \_\_\_\_\_

Age \_\_\_\_\_  Male  Female

### PRE-APPROVED ACCEPTANCE GUARANTEED

You are PRE-APPROVED if you can check (✓) one:

- I have served in the U.S. Military.
- I am the spouse/widow of someone who served in the U.S. Military.
- I am the ancestor (parent/grandparent, etc.) or lineal descendent (child/grandchild, etc.) of someone who served in the U.S. Military.

I meet the following membership criteria for this plan:

- I am a member of AFA and/or AFAVBA
- I am not a member, so I am adding:
  - \$1 for AFAVBA Annual Membership Dues **OR**
  - \$36 for AFA Annual Membership Dues (supports the mission of AFA to promote Air Power, and includes AIR FORCE Magazine monthly, and many more membership benefits)

### Beneficiary Designation:

(please provide Name, Relationship, Social Security # and Percentage if naming more than one Primary Beneficiary)

Beneficiary(ies)	Name	Relationship	Social Security #	%
<b>Primary(ies)</b>				
<b>Contingent</b>				

### Coverage Amounts:

	Common Carrier	Auto/Ped	Other
<b>Plan 1</b>			
Member & Spouse	\$100,000	\$50,000	\$15,000
Children	\$20,000	\$10,000	\$3,000
<b>Plan 2</b>			
Member & Spouse	\$150,000	\$75,000	\$25,000
Children	\$30,000	\$15,000	\$5,000
<b>Plan 3</b>			
Member & Spouse	\$250,000	\$125,000	\$40,000
Children	\$50,000	\$25,000	\$8,000

### Plan of Coverage:

Check One:

	<input type="checkbox"/> Plan 3		<input type="checkbox"/> Plan 2		<input type="checkbox"/> Plan 1	
	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage
Pay Quarterly	\$26.25	\$52.50	\$15.75	\$31.50	\$10.50	\$21.00
Pay Semiannually	\$52.50	\$105.00	\$31.50	\$63.00	\$21.00	\$42.00
Pay Annually	\$105.00	\$210.00	\$63.00	\$126.00	\$42.00	\$84.00

If you are requesting Family coverage, please complete the following for each person to be insured.

	Dependent	Relationship	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Payment Instructions:

A minimum of a quarterly premium must be included with this application either by check or credit card. Future payments can be made by check, credit card, automatic deduction from a checking account, or by government allotment. Please indicate your preferred method of payment on next page.

### Initial Payment:

Check enclosed for:  Quarterly Premium  Semiannual Premium  Annual Premium

Charge my credit card below for:  Quarterly Premium  Semiannual Premium  Annual Premium

### Future Payments:

Bill me directly:  Quarterly  Semiannually  Annually

I will arrange for government allotment; send me details.

I have attached a voided check and give AFAVBA permission to debit my checking account:

Monthly  Quarterly  Semiannually  Annually

Charge my credit card below:  Monthly  Quarterly  Semiannually  Annually

Credit Card Info:  VISA  MasterCard

Credit Card #     -     -     -     Exp. Date   /

Signature \_\_\_\_\_

*I wish to enroll in the AFAVBA Multi-Benefit Accident Insurance Program. I understand that this coverage will become effective on the last day of the month in which my application and correct premium are received, and I certify that I meet the veteran requirements indicated.*

Signature \_\_\_\_\_

Date \_\_\_\_\_

Metropolitan Life Insurance Company Home Office: NY

Mail your completed application and initial payment to: **AFAVBA Member Services, 1501 Lee Highway, Arlington, VA 22209-1198**