

- This application is to increase coverage from Plan _____ to Plan _____ on Policy Certificate # _____.
- This application is to add the Dependent(s) listed below to Policy # _____.
(Member: Answer the medical questions for the Dependents listed only.)



AFAVBA Use Only
 Date/Amt Rcvd _____
 Record # _____
 Dues paid _____
 Met Appr Decl _____
 Cert # _____
 Eff Date _____
 Fam/Ind _____
 Cvg _____
 Prem _____

APPLICATION FOR

AFA VETERAN BENEFITS ASSOCIATION GROUP DECREASING TERM LIFE INSURANCE

Name _____ Rank _____
 Street Address _____
 City _____ State _____ Zip _____
 Daytime Phone _____ E-mail Address _____
 Social Security# _____ Date of Birth (mo/day/yr) _____ Age _____
 Height _____ Weight _____ Male Female
 In the last year, have you used any tobacco products? Yes No

Check (✓) your eligibility:

- 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: For Family coverage, the Member receives the insurance proceeds when an insured Family Member dies. List your beneficiary (ies) in the event of the Member's death. Please provide Name, Relationship and Social Security #. If naming more than one beneficiary, provide percentage. **Primary beneficiaries** are the individuals that you wish to receive the insurance proceeds in the event of your death. You may have them divided among several primary beneficiaries. To do this, indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%. **Contingent beneficiaries** receive the proceeds if all primary beneficiaries predecease the insured. If more room is needed, attach a signed, dated letter stating your preferences. Note: Listing someone as a beneficiary is NOT adding coverage for them. For Family coverage, list dependent information in the Family Coverage section below.

Beneficiary(ies)	Name	Relationship	Social Security #	%
Primary(ies)				
Contingent				

Plan of Coverage: Check One:

	<input type="checkbox"/> Standard		<input type="checkbox"/> High Option		<input type="checkbox"/> High Option Plus		<input type="checkbox"/> Select	
	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage
Pay Monthly*	\$10.00	\$12.50	\$15.00	\$17.50	\$20.00	\$22.50	\$30.00	\$32.50
Pay Quarterly	\$30.00	\$37.50	\$45.00	\$52.50	\$60.00	\$67.50	\$90.00	\$97.50
Pay Semiannually	\$60.00	\$75.00	\$90.00	\$105.00	\$120.00	\$135.00	\$180.00	\$195.00
Pay Annually	\$120.00	\$150.00	\$180.00	\$210.00	\$240.00	\$270.00	\$360.00	\$390.00

*only if paying by auto debit, auto charge or government allotment

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

Dependent	Relationship	Date of Birth	Height	Weight
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Attach list if more room is needed.

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 _____

Answer the following questions for you and any dependents for whom you are requesting coverage:

- 1. Has any person for whom coverage is being requested been hospitalized during the preceding 90 days? Yes No
"Hospitalized" means inpatient confinement for: hospital care, hospice care or care in an intermediate or long-term care facility. It also includes outpatient hospital care for chemotherapy, radiation therapy, or dialysis treatment.
2. Have you ever received treatment for or been told you had:
a. Cancer, tumors, leukemia, Hodgkins disease, or other associated malignancies?
b. Heart disease, high blood pressure, stroke, or other cardiovascular disease?
c. AIDS or AIDS related complex (ARC)?
3. Within the past 3 years have you had chest discomfort, tuberculosis, lung disease, ulcers, diabetes, mental or nervous disorder, neck or spinal disorder?
4. In the past 5 years has any physician or other medical practitioner advised or treated you for any disease, ailment, or injury not revealed elsewhere in this application?
5. Has any application for life or health insurance been declined, postponed or issued other than as applied for?
6. Is the proposed insured receiving (or have a pending request to receive) Workmen's Compensation or any other disability benefit?

If you answered "Yes" to any of the above questions, attach a sheet of paper showing the name of the person to whom your answer applies and provide details, dates, diagnosis, treatment and name and address of the health care provider(s) and hospital(s).

I certify that the information in this application, a copy of which shall be attached to and made a part of my Certificate when issued, is given to obtain the plan requested and is true and complete to the best of my knowledge and belief. I agree that no insurance will be effective until a Certificate has been issued and the initial premium paid. I understand that the coverage will not become effective until approved by MetLife. I understand that if on the Effective Date: (1) I am not eligible for such insurance by reason of (i) age or (ii) membership/veteran requirement status, insurance will not become effective on my life; (2) any person to be insured (including spouse or children) is hospitalized, insurance will not become effective on the life of that person until approved by MetLife; and (3) my spouse is receiving, is entitled to receive or would be entitled to receive upon timely application, any benefit due to sickness or injury (other than medical expense benefits) under any private policy or plan or government program whether insured or noninsured, insurance will not become effective on the life of my spouse until approved by MetLife.

Authorization to Furnish Medical Information: For underwriting and claim purposes, I hereby authorize any physician or other medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization to furnish MetLife, on my behalf, with information in his or its possession, including the findings relating to medical, psychiatric or psychological care or examination, or surgical treatment given to the undersigned. This authorization shall be valid for 2 years. A photocopy of this authorization shall be considered as effective and valid as the original.

Member's Signature _____ Date _____

If applying for Family Coverage: Spouse's Signature _____ Date _____

Dependent Child's Signature (if over 18) _____ 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