NexGen CHILD DEPENDENT LIFE INSURANCE COVERAGE
LOW MONTHLY PREMIUMS

DEPENDENT PREMIUM	
Amount of Coverage	*Cost*
$ 10,000	**$ 1.30**
$ 20,000	**$ 2.00**
$ 25,000	**$ 2.25**

DEPENDENT LIFE INSURANCE COVERAGE

For only a few dollars extra each month, you can obtain valuable group term life insurance protection for your dependent child. The maximum NexGen coverage amount is $25,000.

Eligible dependents are your unmarried dependent children at least 14 days old but under age 21. A child may NOT be insured as a dependent if he or she is already insured as a member of MBA.

The amount of a dependent child's coverage may not exceed the amount of the member's coverage, if less than $25,000. You must apply for the same amount of coverage for all dependent children.

EFFECTIVE DATE OF INSURANCE

Coverage becomes effective on the first day of the month following both (a) approval of your application for insurance and (b) receipt by MBA of the required premium. Please note that the effective date of coverage will be delayed if illness prevents YOUR DEPENDENT CHILD from completing a day of regular employment or if YOUR DEPENDENT CHILD is confined to a hospital, at home under the care of a physician for any medical reason, or if YOUR DEPENDENT CHILD has applied to receive or is receiving disability income from any source for any medical reason. Also, if a family Member is hospitalized the coverage will not begin until the day after she or he is discharged.

CONTINUATION OF COVERAGE AT AGE 25

Coverage terminates for dependent children upon reaching age 25. At that time, if the applicable premium is paid, Dependent Life Coverage will be converted to Adult Former Dependent Life Coverage, in an increased amount, without the need for evidence of insurability.

A current MBA NexGen dependent carrying $10,000 coverage can automatically be insured for $50,000 coverage upon reaching age 25. A NexGen dependent carrying $20,000 or $25,000 can automatically be insured for up to $100,000 upon reaching age 25. To apply for coverage over $100,000, the dependent must complete the appropriate application for determination of insurability.

HOW TO APPLY:

1. Complete the enrollment application form, sign and date where indicated.
2. Mail completed enrollment application form to:

Military Benefit Association
14605 Avion Parkway
P.O. Box 221110
Chantilly, VA 20153-1110

MBA Military Benefit Association

MILITARY BENEFIT ASSOCIATION
14605 Avion Parkway, P.O. Box 221110
Chantilly, VA 20153-1110
(703) 968-6200

http://www.militarybenefit.org

MetLife

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com

MBA Military Benefit Association

MetLife
Metropolitan Life Insurance Company, New York, NY

NEXGEN DEPENDENT CHILD ENROLLMENT • CHANGE FORM

SECTION 1 – Your Enrollment Information (To be Completed by the Member)

Member's Name (First, Middle, Last)	Member's SSN # – –	Date of Birth (MM/DD/YYYY)
☐ Male ☐ Female	☐ Married ☐ Single ☐ Widowed ☐ Divorced	
Current Mailing Address (Street, City, State, Zip Code)		
Permanent Home Address (Street, City, State, Zip Code)		
Home/Cell Phone #	Work Phone #	Email Address

SECTION 2 - NexGen Dependent Child Information

Dependent Child's Name (First, Middle, Last)	Dependent Child's SSN # – –	Date of Birth (MM/DD/YYYY)
☐ Male ☐ Female		

Enter the amount of life insurance (MBA or other) that is in force and applied for on the Dependent Child's:

Father _____ Mother _____ Siblings _____

SECTION 3 – Coverage Selection

I have read my enrollment materials and request the following coverage as indicated below. I understand that contributions are required for the benefit I select below.

☐ **NexGen Dependent Child Life Insurance** [1]

☐ $10,000 ☐ $20,000 ☐ $25,000

Note: NexGen Dependent Child Insurance will be limited to $100, $200, and $250 dollars respectively for a Dependent Child between the ages of 14 days to 6 months based on the amount of NexGen Dependent Child Life Insurance for which you enroll above.

Is this insurance coverage intended to replace any existing life insurance or annuity contracts currently held by you (except for current MBA Term Life Insurance, Servicemembers Group Life Insurance (SGLI) or Federal Employees' Group Life Insurance (FEGLI))? ☐ Yes ☐ No

[1] Amounts will be subject to state limits, if applicable. Your NexGen Dependent Child Life amount may not exceed your amount of the Member Life Insurance.

FOR INTERNAL USE ONLY – Group Customer Information to be completed by the Recordkeeper

Name of Group Customer/Association	Group Customer #	Experience #	Report #	Sub Code
Military Benefit Association (MBA)	**0149107**			

Date of Membership (MM/DD/YYYY)	Member ID #	Coverage Effective Date (MM/DD/YYYY)

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SUBMISSION INSTRUCTIONS

After completion, **sign and date the form on the last page where indicated.** Make a copy for your records and return the original to MILITARY BENEFIT ASSOCIATION, 14605 Avion Parkway, P.O. Box 221110, Chantilly, VA 20153-1110 or fax to (703) 968-6423.

SECTION 4 - Payment Information

☐ Electronic Funds Transfer (complete the EFT section of the Additional Forms and Information sheet)
☐ Credit/debit card authorization for automatic payment. (complete the Credit Card Authorization form)
☐ Check/Money Order for the first three (3) months. DO NOT SEND CASH. Coverage will be effective on the first of the following month, after MetLife approval and receipt of required contributions.
☐ For immediate coverage (effective after MetLife approval and receipt of required contributions) enclose a check/money order for the first three (3) months. DO NOT SEND CASH

SECTION 5 – Tobacco Use

Have you used tobacco in any form in the past 12 months? Dependent Child ☐ Yes ☐ No

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SECTION 6 – Health Information

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Dependent Child Height ___ feet ___ inches Weight ____ pounds

1. Personal Physician's Name: _____
Date of last visit (MM/DD/YYYY): _____ Reason for visit: _____
Address _____ Telephone: (___) ___-____
Street City State Zip Code

2. Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications _____
Medication: _____ Condition/Diagnosis: _____
Prescribing Physician's Name: _____
Address _____ Telephone: (___) ___-____
Street City State Zip Code
☐ Check here if you are attaching another sheet for any additional medications.

For questions 3 through 6, for "yes" answers, please provide full details in the sections below.	**Dependent Child**
3. Have you had any application for life, accidental death and dismemberment or disability insurance ☐ declined; ☐ postponed; ☐ withdrawn; ☐ rated; ☐ modified; or ☐ issued other than as applied for?	☐ Yes ☐ No
4. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	☐ Yes ☐ No
5. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐ Yes ☐ No
6. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: cardiac or cardiovascular disorder; stroke or circulatory disorder; high blood pressure; cancer; blood disorder; diabetes; lung disease; liver or intestinal disorder; mental illness, anxiety, depression, attempted suicide or nervous disorder?	☐ Yes ☐ No

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For questions 7 and 8, for "yes" answers, please provide full details in the sections below.	Dependent Child
7. In the past 5 years, have you been **Hospitalized** as defined below (not including well-baby delivery)?	☐ Yes ☐ No
Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	
8. In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for any other medical condition or had a surgical procedure (other than oral surgery)?	☐ Yes ☐ No

Please provide full details below for each "Yes" answer to questions 3 through 8.

If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.

Question Number(s)	Condition/Diagnosis	Please list any medication prescribed that is not already identified in Section 7 Question 2
Date of Diagnosis (MM/YYYY)	Date of Last Treatment (MM/YYYY)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____ Telephone: (___) ___-____

Street City State Zip Code

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SECTION 7 – Fraud Warnings

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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FW

SECTION 8 – Declarations and Signatures

Member

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
2. I declare that I have completed a day of active duty, regular employment or normal activities on the date I am enrolling. I understand that if I have not completed a day of active duty, regular employment or normal activities on the scheduled effective date of insurance, such insurance will not take effect until the day after completion of the next day of normal activities.
3. I understand that, on the date insurance for a person is scheduled to take effect, the person must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the person does not meet this requirement on such date, the insurance will take effect on the date the person is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

Dependent Child

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
2. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Dependent Child or Signature & Relationship of Personal Representative*		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

*If a child proposed for insurance is age 18 or over, the child must sign above. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

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DEC

FIELD UNDERWRITER SECTION

I HEREBY CERTIFY that the answers given to the foregoing questions on this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of any person proposed for insurance which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notice regarding Information Practices and the Federal Fair Credit were given to the proposed insured.

To the best of your knowledge, is this insurance coverage intended to replace any existing life insurance or annuity contracts currently held by you (except for current MBA Term Life Insurance, Servicemembers Group Life Insurance (SGLI) and Veteran's Group Life Insurance (VGLI))?

☐ Yes ☐ No

Name of Field Underwriter (First, Middle, Last)	Field Underwriter Code #	Agency/Marketing Director Code #	Agency Phone # (_____) _____ – _____

Signature of Field Underwriter	Date Signed (MM/DD/YYYY)

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s)("employee", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; any employer; any group policyholder, contract holder or benefit plan administrator; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured;
  - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Note to All Heath Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, the proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

Signature of Member _____ Date Signed (MM/DD/YYYY) _____

Print Name _____

Sign Here

Signature of Dependent Child or Signature & Relationship of Personal Representative* _____ Date Signed (MM/DD/YYYY) _____

Print Name _____ State of Birth _____ Country of Birth _____

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

ADDITIONAL FORMS & INFORMATION

REQUEST FOR ALLOTMENT

TO: Disbursing or Finance Office Date _____

I request that an allotment be started in the amount of $ _____ for Policy No. 149107-1 payable to:

MILITARY BENEFIT ASSOCIATION, 14605 AVION PARKWAY, P.O. BOX 221110, CHANTILLY, VA 20153-1110

_____ _____

Service Member's Last Name First Name Middle Initial | Service Member's Social Security Number

_____ First monthly deduction effective _____

Service Member's Rate/Rank Branch of Service | Month Year

Blanket Company/Allotment Codes for MBA

USA	K002111	USMC	0065
USN	N06002	USCG	065
USAF	N060025		

_____

Signature of Service Member

EFT AUTHORIZATION

I hereby authorize Military Benefit Association to initiate on or after the fifth day of each month debit entries to my checking account indicated below and on the attached voided check, and I hereby authorize the depository institution named below to debit the same from my account. Said debits shall be for the amount(s) of my monthly premium payments at the regular rates applicable to these premiums. It is understood that the amounts of these debits will be adjusted by MBA in accordance with any applicable premium increases or decreases.

My premium is due and payable on the first of each month. I agree to have two months premium deducted for my first EFT payment if I have not enclosed an initial payment with my application. I further agree that if any such debit should be dishonored, whether with or without cause and whether intentionally or unintentionally, MBA and the depository institution shall be under no liability whatsoever even if termination of insurance results.

This agreement is to remain in full force and effect until MBA has terminated it upon 60 days notice to me, or received notification from me of its termination in such time and manner as to afford MBA a reasonable opportunity to act on it.

_____

Name and address of Bank, Savings & Loan, Credit Union, etc., where you have a personal checking account. (Attach a voided check.)

_____

Routing/Transit Number (First 9 digits from the lower left corner of your personal check).
If your checking account is through a Credit Union, please contact them for the number.

_____

Checking Account No.

_____

Member's Name (Please Print) | Member's Social Security No.

Please deduct my EFT Payments for: ☐ Life Premium

_____

Signature (as it appears on depository records) | Date

IMPORTANT: ***Remember to attach a voided check to this authorization***

CREDIT CARD AUTHORIZATION FORM

ADDITIONAL PREMIUM PAYMENT OPTION

MBA
Military Benefit Association

14605 Avion Parkway
Chantilly VA 20151
1-800-336-0100 FAX 703-968-6423
www.militarybenefit .org

Member/Applicant Name as it appears on card (please print) _____ Member MIN/SSN _____

Personal email address _____ Home Phone Number _____

Alt /Cell Phone Number _____

Billing Address _____

City _____ State _____ Zip Code _____

I authorize Military Benefits Association to charge my:

Select type of card: ☐ VISA ☐ Master Card ☐ Discover

Card Number _____ Expiration Date _____

(Select One Payment Option:) *See Premium table to compute payment amount.*

Quarterly Payment $ _____ *(Monthly Premium X 3)*

Semi-Annual Payment $ _____ *(Monthly Premium X 6)*

Annual Payment $ _____ *(Monthly Premium X 12)*

Please charge my card automatically for recurring payments. *YES* ☐ *NO* ☐

(You will not be billed for future payments, they will be deducted automatically)

I request immediate coverage FOLLOWING APPROVAL and authorize the first deduction on that date. *YES* ☐ *NO* ☐

SIGNATURE _____ **DATE** _____

Agent Information (if applicable):

FU Signature _____

FU Name _____

FU Code# _____

Agency/Marketing Director Code: _____

Agency Telephone Number: _____

PLEASE RETAIN A COPY FOR YOUR RECORDS