

Underwritten by Metropolitan Life Insurance Company (MetLife)

NexGen

ADULT FORMER DEPENDENT LIFE

Welcome to Military Benefit Association (MBA)

We are a nonprofit organization of military personnel, civilian employees of the United States Government, veterans, their spouses, and dependent/former dependent children. We sponsor for our Members an attractive package of insurance and other benefits. Established in 1956, MBA is one of the oldest and largest associations of its kind.



MBA
Military Benefit Association

ELIGIBILITY

You are eligible if you were at one time a dependent child of an MBA member or former MBA member and you are at least age 21 but under age 62.

COVERAGE FEATURES

Amounts Available

As an eligible applicant, you may apply for group term life insurance in amounts up to \$250,000, in units of \$50,000.

Continuous Coverage to Age 70

24 hours a day, anywhere in the world, during times of war and peace. Coverage ends at age 70.

Emergency Death Benefit

An advance payment of up to \$10,000 may be paid to the designated beneficiary on the death of the Insured upon request and verification.

Accelerated Benefits Option¹

For access to funds during a difficult time

You can receive up to 80% of your Term Life insurance proceeds to a maximum of \$500,000 in the event that you become terminally ill and are diagnosed with less than 12 months to live. This can go a long way toward helping your family meet medical and other related expenses at this difficult time.

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 you from completing a day of regular employment or if you are confined to a hospital, at home under the care of

a physician for any medical reason, or if you have applied to receive or are receiving disability income from any source for any medical reason. Also, if a family Member is hospitalized on the date his or her insurance would otherwise go into effect, the coverage will not begin until the day after she or he is discharged.

Conversion Privilege

Members have a conversion privilege upon the occurrence of certain events, including upon termination of group coverage, at age 70, to an individual policy of life insurance with MetLife, as explained in the certificate of coverage.

Exclusion

No benefit will be paid if the Member's or dependent's death occurs from suicide in the first two years of coverage, or if health is misrepresented. Instead, the premium will be refunded.

Cancellation Protection, Termination

Life insurance coverage cannot be terminated prior to age 70, as long as MBA membership continues, the master group policy stays in force, premiums continue to be paid and the above exclusions do not apply.

ADULT FORMER DEPENDENT LIFE MONTHLY PREMIUM/COVERAGE (MALES)

	AGE	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Non Tobacco	Thru 29	\$6.88	\$10.83	\$15.00	\$19.17	\$23.33
	30-34	\$7.50	\$12.08	\$16.88	\$21.67	\$26.46
	35-39	\$8.75	\$13.75	\$19.38	\$25.00	\$30.63
	40-44	\$11.46	\$19.17	\$27.50	\$35.83	\$44.17
	45-49	\$16.67	\$30.42	\$44.38	\$58.33	\$72.29
	50-54	\$20.83	\$36.25	\$53.13	\$70.00	\$86.88
	55-59	\$25.00	\$48.75	\$71.88	\$95.00	\$118.13
	60-64	\$39.17	\$75.83	\$112.50	\$149.17	\$185.83
	65-69	\$62.50	\$122.08	\$181.88	\$241.67	\$301.46
	AGE	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Tobacco	Thru 29	\$13.76	\$21.66	\$30.00	\$38.34	\$46.66
	30-34	\$15.00	\$24.16	\$33.76	\$43.34	\$52.92
	35-39	\$17.50	\$27.50	\$38.76	\$50.00	\$61.26
	40-44	\$22.92	\$38.34	\$55.00	\$71.66	\$88.34
	45-49	\$33.34	\$60.84	\$88.76	\$116.66	\$144.58
	50-54	\$41.66	\$72.50	\$106.26	\$140.00	\$173.76
	55-59	\$50.00	\$97.50	\$143.76	\$190.00	\$236.26
	60-64	\$78.34	\$151.66	\$225.00	\$298.34	\$371.66
	65-69	\$125.00	\$244.16	\$363.76	\$483.34	\$602.92

Premium Rates

Rates are based on your current age on your effective date of coverage. Rates will change when you move into a higher age band or may change at anytime if the entire Group's rates are changed. An increase in your allotment or premium payment will be necessary if one of these events occurs. If you fail to pay the increase in premium, your coverage will be continued, but at a reduced amount.

ADULT FORMER DEPENDENT LIFE MONTHLY PREMIUM/COVERAGE (FEMALES)

	AGE	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Non Tobacco	Thru 29	\$5.21	\$8.33	\$11.25	\$14.17	\$17.08
	30-34	\$6.04	\$10.00	\$13.75	\$17.50	\$21.25
	35-39	\$7.50	\$11.25	\$15.63	\$20.00	\$24.38
	40-44	\$10.21	\$17.92	\$25.63	\$33.33	\$41.04
	45-49	\$12.29	\$20.83	\$30.00	\$39.17	\$48.33
	50-54	\$14.17	\$25.00	\$36.25	\$47.50	\$58.75
	55-59	\$20.83	\$37.92	\$55.63	\$73.33	\$91.04
	60-64	\$35.00	\$66.67	\$98.75	\$130.83	\$162.92
	65-69	\$51.04	\$98.75	\$146.88	\$195.00	\$243.13
	AGE	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Tobacco	Thru 29	\$10.42	\$16.66	\$22.50	\$28.34	\$34.16
	30-34	\$12.08	\$20.00	\$27.50	\$35.00	\$42.50
	35-39	\$15.00	\$22.50	\$31.26	\$40.00	\$48.76
	40-44	\$20.42	\$35.84	\$51.26	\$66.66	\$82.08
	45-49	\$24.58	\$41.66	\$60.00	\$78.34	\$96.66
	50-54	\$28.34	\$50.00	\$72.50	\$95.00	\$117.50
	55-59	\$41.66	\$75.84	\$111.26	\$146.66	\$182.08
	60-64	\$70.00	\$133.34	\$197.50	\$261.66	\$325.84
	65-69	\$102.08	\$197.50	\$293.76	\$390.00	\$486.26

Premium Rates

Rates are based on your current age on your effective date of coverage. Rates will change when you move into a higher age band or may change at anytime if the entire Group's rates are changed. An increase in your allotment or premium payment will be necessary if one of these events occurs. If you fail to pay the increase in premium, your coverage will be continued, but at a reduced amount.

HOW TO APPLY

Complete the Enrollment Application Form

— Requests for membership and insurance must be approved by MBA and MetLife. Be sure to complete the Enrollment Application Form, front and back. Additional evidence of insurability and/or a medical examination may be required. The maximum coverage available on any one individual under any combination of life insurance coverage through MBA with MetLife is \$500,000.

Return the Enrollment Application Form

— You must meet eligibility for membership requirements on the effective date of insurance coverage. Therefore, enrollment application forms must be approved and payment of the first month's premium must be received while you are still eligible. Enrollment application forms should be received at least three months before termination of eligibility.

If immediate life insurance coverage is desired upon approval of the application form, you must enclose a check or money order payable to MBA for three months premium. If monthly premiums are to be paid by Electronic Funds Transfer (EFT) from your bank or credit union, please complete and enclose the EFT Authorization form and include a voided check with the enrollment application form. If premium is to be paid by credit card, please complete and enclose the Credit Card Authorization Form. If EFT or credit card is not available to you, a check or money order for your premiums for three months must be included with the enrollment application form. You will be billed quarterly or semi-annually for future premiums.

Coverage will either be approved by MetLife based upon its underwriting rules and your answers or you will be asked to submit additional medical information in order for MetLife to complete its review of your application for coverage. Coverage is not available in all states and certain state limitations may apply to some provisions. All applications are subject to review and approval by Metropolitan Life Insurance Company based upon its underwriting rules.

¹ The Accelerated Benefits Option is subject to state regulation and is intended to qualify for favorable tax treatment, in which case the benefits will be excludable from income and not subject to federal taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits may have on public assistance eligibility for you, your spouse or your family.

For further assistance or information call us toll free **1-800-336-0100**, 8 am to 4 pm, Monday through Friday, Eastern Time



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



AUXILIARY MEMBER [NEXGEN ADULT FORMER DEPENDENT] ENROLLMENT •CHANGE FORM

SECTION 1 – Your Enrollment Information (To be Completed by the Auxiliary Member)
[NexGen Adult Former Dependent]

Auxiliary Member's Name (First, Middle, Last)		Auxiliary Member's SSN # - -	Date of Birth (MM/DD/YYYY)
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Current Mailing Address (Street, City, State, Zip Code)			
Home/Cell Phone #	Work Phone #	Personal Email Address	

SECTION 2 – Member (Sponsor) Information

Member (sponsor's) Name (First, Middle, Last)	Member (sponsor's) SSN # - -
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SECTION 3 – Coverage Selection

Select one: New Member Current Member Requesting Additional Coverage Current Member Requesting Change in Coverage

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

Auxiliary Member Life Insurance ¹
 \$50,000 \$100,000 \$150,000 \$200,000 \$250,000

NOTE: If I elect to convert my existing NexGen Dependent Child Life Insurance coverage to Adult Former Dependent coverage, medical underwriting is not required for amounts up to and including \$100,000.

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 Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance.

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

Name of Group Customer/Association Military Benefit Association (MBA)	Group Customer # 0149107	Experience #	Report #	Sub Code
Date of Membership (MM/DD/YYYY)	Member ID #	Coverage Effective Date (MM/DD/YYYY)		

GEF02-1
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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?

Auxiliary Member
 Yes No

GEF02-1
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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.

Auxiliary Member 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. Auxiliary Member

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

GEF09-1
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For questions 7 and 8, for "yes" answers, please provide full details in the sections below.

Auxiliary Member

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

GEF09-1
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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.

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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.

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.

**GEF09-1
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SECTION 8 – Beneficiary Designation for Auxiliary Member Insurance

If you have previously designated a beneficiary under this plan, such beneficiary designation will remain in effect. Any MetLife payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below.

I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death.

I understand I have the right to change this designation at any time.

Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. **TOTAL: 100%**

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. **TOTAL: 100%**

SECTION 9 – Declarations and Signatures

Auxiliary 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.

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

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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

If either answer is "Yes", you must attach completed replacement form(s) required by your state.

Name of Field Underwriter (First, Middle, Last)	Field Underwriter Code #	Agency/Marketing Director Code #	Agency Phone # () -
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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 Health 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.



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

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. GP01 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 _____

Service Member's Rate/Rank _____ Branch of Service _____ First monthly deduction effective _____ 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



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 \$

Semi-Annual Payment \$

Annual Payment \$

(Monthly Premium X 3)

(Monthly Premium X 6)

(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