MBA Military Benefit Association

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

# MEMBER LEVEL TERM 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 |
| Rank/Title | Branch of Service | Unit Assignment |

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

## SECTION 2 – Duty Status

☐ Full-time Active Duty ☐ Reserve ☐ National Guard ☐ Academy Cadet
☐ Separated from military Enter separation/expected separation date (MM/DD/YYYY) _____
☐ Retired Enter retirement/expected retirement date (MM/DD/YYYY) _____

## SECTION 3 – Coverage Selection

**I have read my enrollment materials and request Supplemental Term Life Insurance[1, 2] as indicated below. I understand that contributions are required for the benefits I select.**

Enter a multiple of $50,000 up to a maximum of $600,000. $_____

Select a Term: ☐ 10 Year (less than age 65) ☐ 20 Year (less than age 55)

**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

[1] If you are requesting $100,000 or more of Supplemental Dependent Life Insurance, the cost of Dependent Child Insurance is included. For every $50,000 of member coverage elected by you over $100,000, the amount of Dependent Child coverage will increase in multiples of up to $2,500 with a maximum of up to $12,500. Amounts will be subject to state limits, if applicable. If you and your spouse are insured under the same MBA plan, only one plan will carry child coverage.

[2] 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. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

## SECTION 4 – Dependent Child Information

(Provide any additional information on a separate piece of paper and return it with your enrollment form.)

| First Name | MI | Last Name | Date of Birth (MM/DD/YYYY) | ☐ Male ☐ Female |
|---|---|---|---|---|
| First Name | MI | Last Name | Date of Birth (MM/DD/YYYY) | ☐ Male ☐ Female |
| First Name | MI | Last Name | Date of Birth (MM/DD/YYYY) | ☐ Male ☐ Female |
| First Name | MI | Last Name | Date of Birth (MM/DD/YYYY) | ☐ Male ☐ Female |

## SECTION 5 – Tobacco Use

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

## 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) | | |

**GEF02-1**
**ADM**

**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.
**Call 1-800-336-0100 or visit www.militarybenefit.org**



**MBA–ENROLL-LT (02/17)**
Initial____ SSN# (Last 4)_____

## 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.**

Height ___ feet ___ inches Weight _____ pounds

**If you have a Personal Physician, you must include the information below. Otherwise, complete the prescribed medication question.**

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 7, for "yes" answers, please provide full details in the section below.** **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. Are you now receiving or applying for any disability benefits? ☐ Yes ☐ No

5. 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

6. 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

7. 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



**For questions 8 and 9, for "yes" answers, please provide full details in the section below.** **Member**

8. 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.

9. 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 9.** 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

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

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

**Kentucky**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 and Washington**: **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose 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.

**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.

**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.

**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.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

**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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## SECTION 8 – Beneficiary Designation for Member Insurance

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Member.

☐ 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 # | |
| **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 Signature

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 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 dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined or Hospitalized.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. 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) |
|---|---|---|
| | | |

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**DEC**

**SUBMISSION INSTRUCTIONS**

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**Call 1-800-336-0100 or visit www.militarybenefit.org**



**MBA–ENROLL-LT (02/17)**
Initial____ SSN# (Last 4)_____

## Payment Information

I am selecting the following payment option and am including (check one of the boxes below):

☐ A completed EFT authorization (monthly only) form for my checking account.

☐ A completed credit/debit card authorization for automatic payment.

☐ A check/money order for the first three (3) months. Coverage will be effective on the first of the month (subject to MetLife approval) and receipt of required contributions. DO NOT SEND CASH
Select frequency of payment: ☐ Quarterly ☐ Semiannually ☐ Annually

☐ For immediate coverage (subject to MetLife approval) send a check/money order for the first three (3) months. DO NOT SEND CASH

☐ Military Allotment Authorization please visit www.militarybenefit.org to download form.

**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 except current MBA Term Life Insurance, Servicemembers Group Life Insurance (SGLI) and Veteran's Group Life Insurance (VGLI) )?
☐ Yes ☐ No

If the 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 # (_____) _____ – _____ |
|---|---|---|---|
| | | | |

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

## Complete for EFT Authorization only

I hereby authorize Military Benefit Association to initiate on or after the fifth day of each month debit entries to my checking account indicatedbelow 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.**

## Complete for Credit Card Authorization Only

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

Billing Address | Personal Email Address

City | State | Zip | Home Phone Number

I authorize Military Benefit Association to charge my:
Select type of card: ☐ VISA ☐ MasterCard ☐ Discover | Alt / Cell Number

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

# 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; MIB, Group Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; 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 including employment and occupational information;
    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;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

**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. 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 MIB. Such information may also 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 (or his/her authorized representative) 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 Member | | Date Signed (MM/DD/YYYY) |
|---|---|---|
| Print Name | State of Birth | Country of Birth |