

SERFF Tracking Number: FRCS-126375333 State: Arkansas
Filing Company: Government Personnel Mutual Life Insurance Company State Tracking Number: 44089
Company Tracking Number: 5260
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: MBA Term 90 App (MBA_247-A_90)
Project Name/Number: GPM/68/68

Filing at a Glance

Company: Government Personnel Mutual Life Insurance Company

Product Name: MBA Term 90 App (MBA_247-A_90) SERFF Tr Num: FRCS-126375333 State: Arkansas

TOI: L04G Group Life - Term

SERFF Status: Closed-Approved-
Closed State Tr Num: 44089

Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Co Tr Num: 5260

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Bob Motley, Aaron Clark

Disposition Date: 01/06/2010

Date Submitted: 11/12/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: GPM/68

Project Number: 68

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed on or about
this same date.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Association

Filing Status Changed: 01/06/2010

Explanation for Other Group Market Type:

State Status Changed: 11/16/2009

Deemer Date:

Created By: Aaron Clark

Submitted By: Bob Motley

Corresponding Filing Tracking Number:

Filing Description:

We have been retained by Government Personnel Mutual Life Insurance Company to file the enclosed form for approval in your state.

Our fee of \$50 has been sent by EFT on this same date. This fee is based on the state of domicile.

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The application will be used for group certificate GP01-MBA Term 90, which was previously approved by your Department on 07-12-04.

This is an application for a group term product used by members of the Military Benefit Association, located in Chantilly, VA. When used via the internet, the applicant will view the appropriate screens. The internet channel will use an electronic signature process and technology that will allow customers to review and sign their applications online electronically.

The user is required to review each page associated with their application, as it will be printed and attached to a certificate, before entering their initials to "sign" the document. The data is then submitted to the server where a secure hash, used to validate the form data, is calculated. This will ensure the data cannot be altered after submission. On the printed copy "signature submitted electronically" will print on signature line.

For information, we have also included 1) John Doe screenprints of application MBA_247-A_90_(1009), showing all possible screens, one for marrieds and one for singles; 2) John Doe copies of each application, one for married and one for singles, as they would appear attached to the certificate; and 3) screen prints of the pop-up boxes.

When the applicant activates the "filing wizard," he/she will be asked a series of questions. Answers to these will determine the applicable state variation.

Applicable notices and disclosures, based on the applicant's state of residence, will print when the applicant prints the application for his records.

Website has been updated so the applicant may receive the replacement notices when they complete the application if the replacement question is answered "Yes". They are able to print the form and keep for their records.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Aaron Clark, Technician aaron.clark@firstconsulting.com
1020 Central 800-927-2730 [Phone] 2835 [Ext]
Suite 201 816-391-2755 [FAX]
Kansas City, MO 64105

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Filing Company Information

(This filing was made by a third party - FC01)

Government Personnel Mutual Life Insurance CoCode: 63967 State of Domicile: Texas
 Company
 P.O. Box 659567 Group Code: Company Type: Life/Health
 Insurers
 San Antonio, TX 78265-9567 Group Name: State ID Number:
 (210) 357-2222 ext. [Phone] FEIN Number: 74-0651020

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: \$50.00 per form times one form equals \$50.00.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Government Personnel Mutual Life Insurance Company	\$50.00	11/12/2009	32000956

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/06/2010	01/06/2010
Approved-Closed	Linda Bird	11/13/2009	11/13/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	John Doe screenprints of application MBA_247-A_90_(1009)	Aaron Clark	01/05/2010	01/05/2010
Supporting Document	Redline version of Screenprints	Aaron Clark	01/05/2010	01/05/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to reopen filing	Note To Reviewer	Aaron Clark	12/28/2009	12/28/2009

SERFF Tracking Number: FRCS-126375333 State: Arkansas
 Filing Company: Government Personnel Mutual Life Insurance State Tracking Number: 44089
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Authorization		Yes
Supporting Document	Certification of Compliance		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document (revised)	John Doe screenprints of application MBA_247-A_90_(1009)		Yes
Supporting Document	John Doe screenprints of application MBA_247-A_90_(1009)	Replaced	Yes
Supporting Document	John Doe copies of MBA_247- A_90_(1009)		Yes
Supporting Document	Pop up boxes of MBA_247-A_90_(1009)		Yes
Supporting Document	Redline version of Screenprints		Yes
Form	Term Life Insurance Application		Yes

SERFF Tracking Number: FRCS-126375333 *State:* Arkansas
Filing Company: Government Personnel Mutual Life Insurance *State Tracking Number:* 44089
Company
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Disposition

Disposition Date: 11/13/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Authorization		Yes
Supporting Document	Certification of Compliance		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document (revised)	John Doe screenprints of application MBA_247-A_90_(1009)		Yes
Supporting Document	John Doe screenprints of application MBA_247-A_90_(1009)	Replaced	Yes
Supporting Document	John Doe copies of MBA_247- A_90_(1009)		Yes
Supporting Document	Pop up boxes of MBA_247-A_90_(1009)		Yes
Supporting Document	Redline version of Screenprints		Yes
Form	Term Life Insurance Application		Yes

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Amendment Letter

Submitted Date: 01/05/2010

Comments:

Thank you for reopening the filing.

Subsequent to the approval of this filing, the Company modified how the signature section of the "Review" tab on-line version will appear on the internet. The language has been revised to be more user-friendly and readable. Attached are revised copies "John Doe" screenprints of the application. There is a version for a married applicant and another for a single applicant. A red-line version of each is attached to explain the change. This modification does not affect the format of the application which is attached to the certificate. It also does not change any other section of the on-line version of the application.

We trust this information will allow you to finalize review of this filing. If you need any further information or have any questions, please call toll-free 1-800-927-2730. Thank you for your assistance.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: John Doe screenprints of application MBA_247-A_90_(1009)

Comment:

Term 90 married - web shots REV 12-22.pdf

Term 90 single - web shots REV 12-22.pdf

User Added -Name: Redline version of Screenprints

Comment:

Revised Review on-line screen shot - married redline.pdf

Revised Review on-line screen shot - single redline.pdf

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Note To Reviewer

Created By:

Aaron Clark on 12/28/2009 02:03 PM

Last Edited By:

Aaron Clark

Submitted On:

12/28/2009 03:10 PM

Subject:

Request to reopen filing

Comments:

On behalf of the Company, we request you reopen this filing. The reason for this request is that subsequent to the filing, the Company modified how the signature section of the "Review" tab on-line version will appear on the internet. The language has been revised to be more user-friendly and readable. We ask that you reopen the filing so the revised screen shots can be submitted.

We trust this information will allow you to finalize review of this filing. If you need any further information or have any questions, please call toll-free 1-800-927-2730. Thank you for your assistance.

SERFF Tracking Number: *FRCS-126375333* State: *Arkansas*
 Filing Company: *Government Personnel Mutual Life Insurance Company* State Tracking Number: *44089*
 Company Tracking Number: *5260*
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 Project Name/Number: *GPM/68/68*

Form Schedule

Lead Form Number: MBA_247-A_90_(1009)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	MBA_247-A_90_(1009)	Application/Term Life Insurance Enrollment Form	Application	Initial		52.000	MBA_247-A_90_(1009).pdf

MBA Term 90 Life Insurance Coverage

MILITARY BENEFIT ASSOCIATION APPLICATION FORM

Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)
San Antonio, TX

For MBA Administrative

OFFICE USE ONLY

I hereby apply to Government Personnel Mutual Life Insurance Company (GPM Life) for enrollment in life insurance coverage under the group policy issued to the Military Benefit Association.

NAME _____ **SSN** _____
(Please Print) First Middle Initial Last

Actual Age _____ Date of Birth _____ / _____ / _____
Mo Day Yr

Male Married Divorced
 Female Single Legally Separated

Have you used ANY tobacco products during the past 12 months? Yes No

Has your spouse used ANY tobacco products during the past 12 months? Yes No

Current Mailing Address _____
_____ Zip _____

Home Phone: _____
Work Phone: _____
Alternate Phone: _____
E-mail address: _____

Permanent Home Address (Address from which mail will always be forwarded to you.) _____
_____ Zip _____

a. Rank/Title: _____ Branch of Service _____

b. Duty Status: (Check one)

Full-Time Active Duty Retired (Complete item c. below)
 National Guard Academy Cadet
 Ready Reserve ROTC _____ (University)
 Separated from military

Unit Assignment _____
_____ (If none, attach copy of Reserve orders)

Date expected to retire or separate _____ / _____ / _____
Mo Day Yr

c. Retired only — Complete below:

(1) Date of Retirement _____

(2) What type retired pay do you receive?
 Non-Disability Disability None
(If you receive disability retired pay, attach copy of Board action or VA report.)

I am enclosing with this application: (Check one)

A copy of the military allotment authorization form. (I want my life insurance coverage to begin the first day of the month coincident with or next following both (a) approval by GPM Life of my application for insurance and (b) receipt by MBA of the required premium.) Receipt of required premium expected _____ / _____
(Mo./ Yr.)

A completed EFT authorization form for my checking account. (I have attached a voided check.)

A completed Credit and Debit Card authorization form for payment to be automatically charged on a recurring schedule. (I want future premiums to be billed [quarterly/semi-annually/annually].)

A check or money order for my first 3 months premiums. DO NOT SEND CASH. (I want to be billed [quarterly/semi-annually] for future premiums.)

I want immediate coverage FOLLOWING APPROVAL.
(I am enclosing the required check or money order for 3 months premium.) DO NOT SEND CASH. (Immediate coverage not available for ARIZONA residents.)

CHECK ONE: New Member Additional Coverage Change in Coverage

YOUR COVERAGE

Check Box, Compute Premium

[\$50,000] \$100,000 \$150,000 \$200,000 \$250,000]

A. Monthly premium for one \$50,000 unit = \$ _____

B. Number of units of coverage X _____

C. Your monthly premium (A x B) = \$ _____

If you elect a minimum of 2 units (\$100,000) on your life, each child may be covered, AT NO EXTRA COST, for \$2,500 per unit you purchased on your life. Child benefits are \$500 per unit at age 14 days to 6 months, then \$2,500 per unit to age 21, or age 25 if a full-time student in an accredited school. A maximum of \$12,500 is available for each child.

SPOUSE COVERAGE

Check Box, Compute Premium and list spouse information in FAMILY LIFE INSURANCE COVERAGE section below.

[\$25,000] \$50,000 \$75,000 \$100,000 \$125,000
 \$150,000 \$175,000 \$200,000 \$225,000 \$250,000]

A. Monthly premium for one \$25,000 unit = \$ _____

B. Number of units of coverage X _____

C. Spouse's monthly premium (A x B) = \$ _____

*The amount of spouse coverage may not exceed the amount of Member coverage.

TOTAL MONTHLY COST: Your Premium \$ _____
Spouse Premium + \$ _____
Total Monthly Cost \$ _____

FAMILY LIFE INSURANCE COVERAGE

If applying for this coverage, please list your spouse and all unmarried dependent children under age 21, or age 25 if enrolled full-time in an accredited school. Specify relationship if other than your natural child.

NAME	DATE OF BIRTH	DEPENDENT'S RELATIONSHIP

NAME _____ SSN _____
 (Please Print) First Middle Last

INSURABILITY QUESTIONS: These questions pertain to **everyone** to be insured for life insurance coverage. (For South Carolina residents: Failure to completely and correctly answer the questions below may result in coverage being contested from its effective date).

Applicant's Height _____ Weight _____ Spouse's Height _____ Weight _____
 (if applying for family life insurance coverage)

Child's Name, Height and Weight _____
 (if applying for family life insurance coverage)

	Yourself		Dependents	
1. Has any person to be insured ever had or been treated for cancer, heart or circulatory trouble, high blood pressure, diabetes, psychiatric conditions, neurological impairment, disorders of the kidney, liver, gastrointestinal system or blood, respiratory disorders, alcohol or drug abuse, Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the antibodies to the HIV virus?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Yes	No
2. Currently, or during the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized, had an operation or been under any kind of prescribed medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Yes	No
3. In the past 5 years, has any person to be insured been convicted of 2 or more moving violations, or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driver's License No./State _____	Yes	No	Yes	No
4. In the past 5 years, has any person to be insured engaged in: ballooning, cave exploration, parachuting, hang gliding, vehicle racing, scuba diving, mountain climbing or made any flight other than as a passenger?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Yes	No

If the answer to any of the above questions is "Yes", give complete details below. (If necessary, use a separate sheet of paper and attach it to the application.)

Name of Person	Illness or Condition — Date of Onset — Duration — Treatment — Operations — Medication — Degree of Recovery and Date	Name and address of Physician or other Practitioners and Hospitals where confined or treated

I designate as my BENEFICIARY (List full given name; i.e., Mary L. Smith, not Mrs. John Smith.)

Primary Beneficiary _____ Relationship _____

Contingent Beneficiary _____ Relationship _____
 (If primary beneficiary does not survive me)

Continued on next page....

NAME _____ SSN _____

(Please Print) First Middle Last

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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maryland: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

For residents of 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 include imprisonment, fines, and denial of insurance benefits.

For residents of 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 state law.

For residents of 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

I understand that rates are based on current age on effective date of coverage and apply for the first twelve months, excluding age group changes. Although rates have not changed in the past, the rates can be changed in any year after issuance of coverage. Group premium rates may be increased but only if they are increased for all insureds of the same risk class and coverage category. It will be necessary for you to increase your premium payment when premiums increase. If you fail to pay the increase in premium, your coverage will be continued, but in a reduced amount.

I agree that coverage will not become effective for me or my dependents until the first day of the month coincident with or next following both (a) approval by Government Personnel Mutual Life Insurance Company of this application for insurance and (b) receipt by MBA of the required premium, unless I requested immediate coverage on the application and it is approved by Government Personnel Mutual Life Insurance Company. I understand that if I am under medical care requiring absence from regular duties or full-time employment, or normal activities on the scheduled effective date, the insurance will not become effective until the day after completion of the next day of regular duties or full-time employment or normal activities, and that if my dependent is confined in a hospital or other institution for medical care or treatment on the date he or she would otherwise become insured, insurance will not become effective until the day following his or her release from the hospital or other institution.

No sales agent or broker may make or modify the insurance contract or waive any requirement for coverage. Only an officer of Government Personnel Mutual Life Insurance Company can do these things.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or the Department of Motor Vehicles having information as to the mental or physical

health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me or my minor children, to give such information to Government Personnel Mutual Life Insurance company or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except Medical Information Bureau, Inc., to give such information to any agent or insurance support organization acting for Government Personnel Mutual Life Insurance Company or its reinsurer(s).

Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by Government Personnel Mutual Life Insurance Company to its reinsurer(s), the Medical Information Bureau, Inc. in connection with my application or claim, or as may be otherwise lawfully required.

I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. (For Virginia residents: I agree that this form will remain valid for 30 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, and for the duration of a claim for benefits.) I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices," "Investigative Consumer Reports," and "Medical Information Bureau, Inc." from Government Personnel Mutual Life Insurance Company.

Do you now have any life insurance or annuity contract? ___ Yes ___ No.

Is the insurance applied for intended to replace any existing insurance or annuity contract? ___ Yes ___ No.

By my signature below, I attest that the answers and statements, each of which I have made and read, are complete and true and shall form the basis for the issuance of insurance.

Signature of APPLICANT Signed At (City/State) Date

Signature of the SPOUSE Signed At (City/State) Date

If you made any corrections on this form, please initial each correction.

Please make check or money order payable to: MBA

Send the application to: MILITARY BENEFIT ASSOCIATION, 14605 Avion Parkway, P.O. Box 221110, Chantilly, VA 20153-1110

MBA_247-A_90_(1009)

(1009) web

FIELD UNDERWRITER (F.U.) SECTION (if applicable)

I HEREBY CERTIFY that the answers given to the foregoing questions in 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, the Federal Fair Credit Reporting Act, and Medical Information Bureau, Inc. were given to the Primary Proposed Insured.

To the best of your knowledge, a) has the applicant any existing life insurance or annuity contract? ___ Yes ___ No. b) is any insurance or annuity in this or any other company being replaced as a result of this application? ___ Yes ___ No. If either answer is "Yes", F.U. must attach completed replacement form(s) required by your state.

Agent Signature _____

Agent License # _____

F.U. Name _____

Agency/Marketing Director Code # _____

F.U. Code # _____

Agency Name/Telephone # _____

MBA_247-A_90_(1009)

(1009) web



MILITARY BENEFIT ASSOCIATION

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

www.militarybenefit.org



*This coverage is underwritten by
Government Personnel Mutual Life Insurance
Company (GPM) under policy number GP01.
Not available in all states.*

www.gpmlife.com

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR RDB.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Not applicable for this filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Authorization		
Comments:		
Attachment: Authorization 2009 DIST.pdf		

	Item Status:	Status Date:
Satisfied - Item: Certification of Compliance		
Comments:		
Attachment: AR coc.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		

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Comments:

Attachment:

SOV MBA_247-A_90_(1009).pdf

Item Status: **Status**
Date:

Satisfied - Item: John Doe screenprints of application MBA_247-A_90_(1009)

Comments:

Attachments:

Term 90 married - web shots REV 12-22.pdf

Term 90 single - web shots REV 12-22.pdf

Item Status: **Status**
Date:

Satisfied - Item: John Doe copies of MBA_247-A_90_(1009)

Comments:

Attachments:

Print 247-A-90 1009 - John Doe attached to certificate - married.pdf

Print 247-A-90 1009 - John Doe attached to certificate - single.pdf

Item Status: **Status**
Date:

Satisfied - Item: Pop up boxes of MBA_247-A_90_(1009)

Comments:

Attachment:

Pop-Up Boxes - web shots.pdf

Item Status: **Status**
Date:

Satisfied - Item: Redline version of Screenprints

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: Government Personnel Mutual Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
MBA 247-A 90 (1009)	52.1



Pamela Hutchins, FSA, MAAA
Senior Vice President and Chief Actuary

November 6, 2009

Date

GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY

GPM LIFE Building, 2211 NE Loop 410, P.O. Box 659567, San Antonio, Texas 78265-9567

(210) 357-2222 Fax (210) 357-6722 (800) 929-4765

FEB 23 2009

Date

To The Insurance Commissioner

AUTHORIZATION

This letter, or a copy thereof, authorizes the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, and its employees, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Government Personnel Mutual Life Insurance Company
Company

Signature: _____



Name: Pamela Hutchins, FSA, MAAA

Title: Senior Vice President and Chief Actuary

**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: Government Personnel Mutual Life Insurance Company

Form Title(s): Term Life Insurance Application

Form Number(s): MBA_247-A_90_(1009)

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Pamela Hutchins, FSA, MAAA
Senior Vice President and Chief Actuary

November 6, 2009

Date

Statement of Variability

INSURER - GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY
P. O. BOX 659567, SAN ANTONIO, TEXAS 78265-9567

FORM NUMBER MBA_247-A_90_(1009)

The coverage amounts shown in this form are bracketed and are intended to be variable.

1. The range for the amount available in the "Your Coverage" Section will be as follows:

\$50,000 - \$500,000

2. The range for the amount available in the "Spouse Coverage" Section will be as follows:

\$25,000 - \$500,000



Pamela Hutchins, FSA, MAAA

Senior Vice President and Chief Actuary

10/26/09

DATE

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant Spouse **Family** Health Other Payment Review

Let's get started by collecting information about you, the applicant. This form will adjust dynamically as you respond to each question in order to alert you to input errors and hide questions that are not relevant to your application.

Current coverage

Please select the option that best describes your current relationship with MBA.

- I am a new member.
- I am requesting additional coverage.
- I am requesting a change in coverage.

Contact information

First name Middle initial Last name

Home phone Work phone Alternate phone

E-mail address

Current mailing address

Street number and name
(1234 Main St.)

City State Zip

Permanent home address (Address from which mail will always be forwarded to you)

Street number and name
(1234 Main St.)

City State Zip

Personal information

Sex Male Female Marital status Single Married Divorced Legally Separated

Date of birth Social Security Number (SSN)
(mm/dd/yyyy) (xxx-xx-xxxx)

Height Weight
(5' 10") (lbs)

Have you used any tobacco products during the past 12 months?

Yes No

Service information

Branch of service

Air Force Army Coast Guard

Marine Corps Navy

Rank/Title

COL

Duty Status

Full-Time Active Duty Retired National Guard

Academy Cadet Ready Reserve ROTC

Separated from military

Date expected to retire or separate

11/01/2012
(mm/dd/yyyy)

Unit assignment

US AIR CORP
(If none, mail or fax copy of Reserve orders)

Requested coverage

Coverage Amount

\$50,000 \$100,000 \$150,000 \$200,000 \$250,000

Primary beneficiary

Jane Doe
(full given name; i.e., Mary L. Smith, not Mrs. John Smith)

Relationship

Wife

Contingent beneficiary

(if primary beneficiary does not survive me)

Relationship

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant

Spouse

Family

Health

Other

Payment

Review

Please provide information about your spouse. Note that spouse coverage limits are based on your applicant coverage selection. For additional coverage options return to the applicant tab and increase your coverage.

A spouse may NOT be insured as a dependent if he or she is insured as a Member of MBA.

Coverage

Spouse's coverage amount

- \$25,000
 \$50,000
 \$75,000
 \$100,000
 \$125,000
 \$150,000
 \$175,000
 \$200,000
 \$225,000
 \$250,000
 None

Personal information

Name

Jane Doe

Date of birth

10/26/1976

(mm/dd/yyyy)

Social Security Number (SSN)

232-65-4654

(xxx-xx-xxxx)

Height

5' 7"

(5' 7")

Weight

180

(lbs)

Has your spouse used any tobacco products during the past 12 months?

- Yes
 No

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant	Spouse	Family	Health	Other	Payment	Review
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Health information

Has any person to be insured ever had or been treated for cancer, heart or circulatory trouble, high blood pressure, diabetes, psychiatric conditions, neurological impairment, disorders of the kidney, liver, gastrointestinal system or blood, respiratory disorders, alcohol or drug abuse, Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the antibodies to the HIV virus?

Yourself Yes No Dependents Yes No

Currently, or during the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized, had an operation or been under any kind of prescribed medication?

Yourself Yes No Dependents Yes No

In the past 5 years, has any person to be insured been convicted of 2 or more moving violations, or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked?

Yourself Yes No Dependents Yes No

In the past 5 years, has any person to be insured engaged in: ballooning, cave exploration, parachuting, hang gliding, vehicle racing, scuba diving, mountain climbing or made any flight other than as a passenger?

Yourself Yes No Dependents Yes No

[MBA_247-A_90_\(1009\)](#)

[CONTINUE >>](#)

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant

Spouse

Family

Health

Other

Payment

Review

Please tell us about any existing life insurance or annuity contracts you may hold.

Other Coverage

Do you now have any life insurance or annuity contract?

Yes No

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant

Spouse

Family

Health

Other

Payment

Review

Military Benefit Association offers a number of convenient ways to pay your premium. Please choose a payment method and complete the required fields.

Payment options

How would you like to pay your premium?

- Allotment deducted directly from my military or government paycheck.
- Electronic Funds Transfer (EFT) directly from my personal checking account.
- VISA, Master Card or Discover credit/debit card to be charged automatically on a recurring schedule.
- Check or Money Order. You will have the option to pay quarterly, semi-annually or annually and will receive premium due notices four to six weeks prior to premium being due.

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant

Spouse

Family

Health

Other

Payment

Review

Please review your completed forms and provide an electronic signature to submit your application. Take your time and review these documents thoroughly. By electronically signing them, you will be entering into a legally binding agreement with Military Benefit Association. You should save or print a copy of each of these forms for your records.

The information you've entered during the interview process will be available until you close your web browser or navigate away from this page. If you need to make corrections to any of your answers, simply click the appropriate tab, make the desired changes and return to the review tab to preview the changed documents.

Application Forms

Brochure and Application

I have taken all the information you provided and completed the application form for you. Please read your completed application from start to finish as it contains the full details of your agreement with Military Benefit Association.



Applicant Health-Related Information Release

This form authorizes the release of your medical records, if necessary, from your care providers for the purpose of determining insurability and is required by federal law.



Spouse Health-Related Information Release

This form authorizes the release of your spouse's medical records, if necessary, from your care providers for the purpose of determining insurability and is required by federal law if spouse coverage is requested.



Signature

You must answer the following questions to electronically sign these forms.

City where this application is being completed

State where this application is being completed Your initials

MBA_247-A_90_(1009)

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant Spouse Family Health Other Payment Review

Let's get started by collecting information about you, the applicant. This form will adjust dynamically as you respond to each question in order to alert you to input errors and hide questions that are not relevant to your application.

Current coverage

Please select the option that best describes your current relationship with MBA.

- I am a new member.
- I am requesting additional coverage.
- I am requesting a change in coverage.

Contact information

First name Middle initial Last name

Home phone Work phone Alternate phone

E-mail address

Current mailing address

Street number and name
(1234 Main St.)

City State Zip

Permanent home address (Address from which mail will always be forwarded to you)

Street number and name
(1234 Main St.)

City State Zip

Personal information

Sex Male Female Marital status Single Married Divorced Legally Separated

Date of birth Social Security Number (SSN)
(mm/dd/yyyy) (xxx-xx-xxxx)

Height Weight
(5' 10") (lbs)

Have you used any tobacco products during the past 12 months?

Yes No

Service information

Branch of service

Air Force Army Coast Guard

Marine Corps Navy

Rank/Title

COL

Duty Status

Full-Time Active Duty Retired National Guard

Academy Cadet Ready Reserve ROTC

Separated from military

Date expected to retire or separate

11/01/2012

(mm/dd/yyyy)

Unit assignment

US AIR CORP

(If none, mail or fax copy of Reserve orders)

Requested coverage

Coverage Amount

\$50,000 \$100,000 \$150,000 \$200,000 \$250,000

Primary beneficiary

Jane Doe

(full given name; i.e., Mary L. Smith, not Mrs. John Smith)

Relationship

Sister

Contingent beneficiary

(if primary beneficiary does not survive me)

Relationship

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant

Spouse

Family

Health

Other

Payment

Review

Health information

Has any person to be insured ever had or been treated for cancer, heart or circulatory trouble, high blood pressure, diabetes, psychiatric conditions, neurological impairment, disorders of the kidney, liver, gastrointestinal system or blood, respiratory disorders, alcohol or drug abuse, Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the antibodies to the HIV virus?

Yes No

Currently, or during the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized, had an operation or been under any kind of prescribed medication?

Yes No

In the past 5 years, has any person to be insured been convicted of 2 or more moving violations, or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked?

Yes No

In the past 5 years, has any person to be insured engaged in: ballooning, cave exploration, parachuting, hang gliding, vehicle racing, scuba diving, mountain climbing or made any flight other than as a passenger?

Yes No

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant

Spouse

Family

Health

Other

Payment

Review

Please tell us about any existing life insurance or annuity contracts you may hold.

Other Coverage

Do you now have any life insurance or annuity contract?

Yes No

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant

Spouse

Family

Health

Other

Payment

Review

Military Benefit Association offers a number of convenient ways to pay your premium. Please choose a payment method and complete the required fields.

Payment options

How would you like to pay your premium?

- Allotment deducted directly from my military or government paycheck.
- Electronic Funds Transfer (EFT) directly from my personal checking account.
- VISA, Master Card or Discover credit/debit card to be charged automatically on a recurring schedule.
- Check or Money Order. You will have the option to pay quarterly, semi-annually or annually and will receive premium due notices four to six weeks prior to premium being due.

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant

Spouse

Family

Health

Other

Payment

Review

Please review your completed forms and provide an electronic signature to submit your application. Take your time and review these documents thoroughly. By electronically signing them, you will be entering into a legally binding agreement with Military Benefit Association. You should save or print a copy of each of these forms for your records.

The information you've entered during the interview process will be available until you close your web browser or navigate away from this page. If you need to make corrections to any of your answers, simply click the appropriate tab, make the desired changes and return to the review tab to preview the changed documents.

Application Forms

Brochure and Application

I have taken all the information you provided and completed the application form for you. Please read your completed application from start to finish as it contains the full details of your agreement with Military Benefit Association.



Applicant Health-Related Information Release

This form authorizes the release of your medical records, if necessary, from your care providers for the purpose of determining insurability and is required by federal law.



Signature

You must answer the following questions to electronically sign these forms.

City where this application is being completed

State where this application is being completed

Your initials

JAD

MBA_247-A_90_(1009)

MBA Term 90 Life Insurance Coverage

MILITARY BENEFIT ASSOCIATION APPLICATION FORM

Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)
San Antonio, TX

For MBA Administrative

OFFICE USE ONLY

I hereby apply to Government Personnel Mutual Life Insurance Company (GPM Life) for enrollment in life insurance coverage under the group policy issued to the Military Benefit Association.

NAME John A Doe **SSN** 123-56-7898
(Please Print) First Middle Initial Last

Actual Age 35 Date of Birth 10 / 01 / 1974
Mo Day Yr

Male Married Divorced
 Female Single Legally Separated

Have you used ANY tobacco products during the past 12 months? Yes No

Has your spouse used ANY tobacco products during the past 12 months? Yes No

Current Mailing Address
1234 Main St.
Anytown, AL Zip 12356-4565

Home Phone: 210-357-2222
Work Phone: 210-357-2222
Alternate Phone: 210-357-2222
E-mail address: jdoe@yahoo.com

Permanent Home Address (Address from which mail will always be forwarded to you.)
1234 Main St.
Anytown, AL Zip 12356-4565

a. Rank/Title: COL Branch of Service Air Force

b. Duty Status: (Check one)
 Full-Time Active Duty Retired (Complete item c. below)
 National Guard Academy Cadet
 Ready Reserve ROTC _____ (University)
 Separated from military

Unit Assignment US AIR CORP

(If none, attach copy of Reserve orders)

Date expected to retire or separate 11 / 01 / 2012
Mo Day Yr

c. Retired only — Complete below:
(1) Date of Retirement _____
(2) What type retired pay do you receive?
 Non-Disability Disability None
(If you receive disability retired pay, attach copy of Board action or VA report.)

I am enclosing with this application: (Check one)
 A copy of the military allotment authorization form. (I want my life insurance coverage to begin the first day of the month coincident with or next following both (a) approval by GPM Life of my application for insurance and (b) receipt by MBA of the required premium.) Receipt of required premium expected _____ / _____ (Mo./ Yr.)
 A completed EFT authorization form for my checking account. (I have attached a voided check.)
 A completed Credit and Debit Card authorization form for payment to be automatically charged on a recurring schedule. (I want future premiums to be billed [quarterly/semi-annually/annually].)
 A check or money order for my first 3 months premiums. DO NOT SEND CASH. (I want to be billed [quarterly/semi-annually] for future premiums.)
 I want immediate coverage FOLLOWING APPROVAL.
(I am enclosing the required check or money order for 3 months premium.) DO NOT SEND CASH. (Immediate coverage not available for ARIZONA residents.)

CHECK ONE: New Member Additional Coverage Change in Coverage

YOUR COVERAGE

Check Box, Compute Premium

\$50,000 \$100,000 \$150,000 \$200,000 \$250,000

A. Monthly premium for one \$50,000 unit = \$ 3.25

B. Number of units of coverage X 1

C. Your monthly premium (A x B) = \$ 3.25

If you elect a minimum of 2 units (\$100,000) on your life, each child may be covered, AT NO EXTRA COST, for \$2,500 per unit you purchased on your life. Child benefits are \$500 per unit at age 14 days to 6 months, then \$2,500 per unit to age 21, or age 25 if a full-time student in an accredited school. A maximum of \$12,500 is available for each child.

SPOUSE COVERAGE

Check Box, Compute Premium and list spouse information in FAMILY LIFE INSURANCE COVERAGE section below.

\$25,000 \$50,000 \$75,000 \$100,000 \$125,000
 \$150,000 \$175,000 \$200,000 \$225,000 \$250,000

A. Monthly premium for one \$25,000 unit = \$ 1.65

B. Number of units of coverage X 1

C. Spouse's monthly premium (A x B) = \$ 1.65

*The amount of spouse coverage may not exceed the amount of Member coverage.

TOTAL MONTHLY COST: Your Premium \$ 3.25
Spouse Premium + \$ 1.65
Total Monthly Cost \$ 4.90

FAMILY LIFE INSURANCE COVERAGE

If applying for this coverage, please list your spouse and all unmarried dependent children under age 21, or age 25 if enrolled full-time in an accredited school. Specify relationship if other than your natural child.

NAME	DATE OF BIRTH	DEPENDENT'S RELATIONSHIP
Jane Doe	10/26/1976	wife

INSURABILITY QUESTIONS: These questions pertain to **everyone** to be insured for life insurance coverage. (For South Carolina residents: Failure to completely and correctly answer the questions below may result in coverage being contested from its effective date).

Applicant's Height 5' 10" Weight 210 Spouse's Height 5' 7" Weight 180
 (if applying for family life insurance coverage)

Child's Name, Height and Weight _____
 (if applying for family life insurance coverage)

	Yourself		Dependents	
1. Has any person to be insured ever had or been treated for cancer, heart or circulatory trouble, high blood pressure, diabetes, psychiatric conditions, neurological impairment, disorders of the kidney, liver, gastrointestinal system or blood, respiratory disorders, alcohol or drug abuse, Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the antibodies to the HIV virus?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Yes	No	Yes	No
2. Currently, or during the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized, had an operation or been under any kind of prescribed medication?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Yes	No	Yes	No
3. In the past 5 years, has any person to be insured been convicted of 2 or more moving violations, or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Yes	No	Yes	No
Driver's License No./State _____				
4. In the past 5 years, has any person to be insured engaged in: ballooning, cave exploration, parachuting, hang gliding, vehicle racing, scuba diving, mountain climbing or made any flight other than as a passenger?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Yes	No	Yes	No

If the answer to any of the above questions is "Yes", give complete details below. (If necessary, use a separate sheet of paper and attach it to the application.)

Name of Person	Illness or Condition — Date of Onset — Duration — Treatment — Operations — Medication — Degree of Recovery and Date	Name and address of Physician or other Practitioners and Hospitals where confined or treated

I designate as my BENEFICIARY (List full given name; i.e., Mary L. Smith, not Mrs. John Smith.)

Primary Beneficiary Jane Doe Relationship Wife

Contingent Beneficiary _____ Relationship _____
 (If primary beneficiary does not survive me)

Continued on next page....

NAME John A Doe SSN 123-56-7898
(Please Print) First Middle Last

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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maryland: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

For residents of 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 include imprisonment, fines, and denial of insurance benefits.

For residents of 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 state law.

For residents of 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

I understand that rates are based on current age on effective date of coverage and apply for the first twelve months, excluding age group changes. Although rates have not changed in the past, the rates can be changed in any year after issuance of coverage. Group premium rates may be increased but only if they are increased for all insureds of the same risk class and coverage category. It will be necessary for you to increase your premium payment when premiums increase. If you fail to pay the increase in premium, your coverage will be continued, but in a reduced amount.

I agree that coverage will not become effective for me or my dependents until the first day of the month coincident with or next following both (a) approval by Government Personnel Mutual Life Insurance Company of this application for insurance and (b) receipt by MBA of the required premium, unless I requested immediate coverage on the application and it is approved by Government Personnel Mutual Life Insurance Company. I understand that if I am under medical care requiring absence from regular duties or full-time employment, or normal activities on the scheduled effective date, the insurance will not become effective until the day after completion of the next day of regular duties or full-time employment or normal activities, and that if my dependent is confined in a hospital or other institution for medical care or treatment on the date he or she would otherwise become insured, insurance will not become effective until the day following his or her release from the hospital or other institution.

No sales agent or broker may make or modify the insurance contract or waive any requirement for coverage. Only an officer of Government Personnel Mutual Life Insurance Company can do these things.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or the Department of Motor Vehicles having information as to the mental or physical

health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me or my minor children, to give such information to Government Personnel Mutual Life Insurance company or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except Medical Information Bureau, Inc., to give such information to any agent or insurance support organization acting for Government Personnel Mutual Life Insurance Company or its reinsurer(s).

Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by Government Personnel Mutual Life Insurance Company to its reinsurer(s), the Medical Information Bureau, Inc. in connection with my application or claim, or as may be otherwise lawfully required.

I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. (For Virginia residents: I agree that this form will remain valid for 30 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, and for the duration of a claim for benefits.) I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices," "Investigative Consumer Reports," and "Medical Information Bureau, Inc." from Government Personnel Mutual Life Insurance Company.

Do you now have any life insurance or annuity contract? ___ Yes No.

Is the insurance applied for intended to replace any existing insurance or annuity contract? ___ Yes No.

By my signature below, I attest that the answers and statements, each of which I have made and read, are complete and true and shall form the basis for the issuance of insurance.

signature submitted electronically Anytown2, AL 10/01/2009
Signature of APPLICANT Signed At (City/State) Date

Signature of the SPOUSE Signed At (City/State) Date

If you made any corrections on this form, please initial each correction.

Please make check or money order payable to: MBA

Send the application to: MILITARY BENEFIT ASSOCIATION, 14605 Avion Parkway, P.O. Box 221110, Chantilly, VA 20153-1110

MBA_247-A_90_(1009)

(1009) web

FIELD UNDERWRITER (F.U.) SECTION (if applicable)

I HEREBY CERTIFY that the answers given to the foregoing questions in 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, the Federal Fair Credit Reporting Act, and Medical Information Bureau, Inc. were given to the Primary Proposed Insured.

To the best of your knowledge, a) has the applicant any existing life insurance or annuity contract? ___ Yes ___ No. b) is any insurance or annuity in this or any other company being replaced as a result of this application? ___ Yes ___ No. If either answer is "Yes", F.U. must attach completed replacement form(s) required by your state.

Agent Signature _____ Agent License # _____
F.U. Name _____ Agency/Marketing Director Code # _____
F.U. Code # _____ Agency Name/Telephone # _____

MBA_247-A_90_(1009)

(1009) web



MILITARY BENEFIT ASSOCIATION

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

www.militarybenefit.org



*This coverage is underwritten by
Government Personnel Mutual Life Insurance
Company (GPM) under policy number GP01.
Not available in all states.*

www.gpmlife.com

MBA Term 90 Life Insurance Coverage

MILITARY BENEFIT ASSOCIATION APPLICATION FORM

Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)
San Antonio, TX

For MBA Administrative

OFFICE USE ONLY

I hereby apply to Government Personnel Mutual Life Insurance Company (GPM Life) for enrollment in life insurance coverage under the group policy issued to the Military Benefit Association.

NAME John A Doe **SSN** 123-56-7898
(Please Print) First Middle Initial Last

Actual Age 35 Date of Birth 10 / 01 / 1974
Mo Day Yr

Male Married Divorced
 Female Single Legally Separated

Have you used ANY tobacco products during the past 12 months? Yes No

Has your spouse used ANY tobacco products during the past 12 months? Yes No

Current Mailing Address
1234 Main St.
Anytown, AL Zip 12356-4565

Home Phone: 210-357-2222
Work Phone: 210-357-2222
Alternate Phone: 210-357-2222
E-mail address: jdoe@yahoo.com

Permanent Home Address (Address from which mail will always be forwarded to you.)
1234 Main St.
Anytown, AL Zip 12356-4565

a. Rank/Title: COL Branch of Service Air Force

b. Duty Status: (Check one)
 Full-Time Active Duty Retired (Complete item c. below)
 National Guard Academy Cadet
 Ready Reserve ROTC _____ (University)
 Separated from military

Unit Assignment US AIR CORP

(If none, attach copy of Reserve orders)

Date expected to retire or separate 11 / 01 / 2012
Mo Day Yr

c. Retired only — Complete below:
(1) Date of Retirement _____
(2) What type retired pay do you receive?
 Non-Disability Disability None
(If you receive disability retired pay, attach copy of Board action or VA report.)

I am enclosing with this application: (Check one)
 A copy of the military allotment authorization form. (I want my life insurance coverage to begin the first day of the month coincident with or next following both (a) approval by GPM Life of my application for insurance and (b) receipt by MBA of the required premium.) Receipt of required premium expected _____ / _____ (Mo./ Yr.)
 A completed EFT authorization form for my checking account. (I have attached a voided check.)
 A completed Credit and Debit Card authorization form for payment to be automatically charged on a recurring schedule. (I want future premiums to be billed [quarterly/semi-annually/annually].)
 A check or money order for my first 3 months premiums. DO NOT SEND CASH. (I want to be billed [quarterly/semi-annually] for future premiums.)
 I want immediate coverage FOLLOWING APPROVAL.
(I am enclosing the required check or money order for 3 months premium.) DO NOT SEND CASH. (Immediate coverage not available for ARIZONA residents.)

CHECK ONE: New Member Additional Coverage Change in Coverage

YOUR COVERAGE

Check Box, Compute Premium

\$50,000 \$100,000 \$150,000 \$200,000 \$250,000

A. Monthly premium for one \$50,000 unit = \$ 3.25

B. Number of units of coverage X 1

C. Your monthly premium (A x B) = \$ 3.25

If you elect a minimum of 2 units (\$100,000) on your life, each child may be covered, AT NO EXTRA COST, for \$2,500 per unit you purchased on your life. Child benefits are \$500 per unit at age 14 days to 6 months, then \$2,500 per unit to age 21, or age 25 if a full-time student in an accredited school. A maximum of \$12,500 is available for each child.

SPOUSE COVERAGE

Check Box, Compute Premium and list spouse information in FAMILY LIFE INSURANCE COVERAGE section below.

\$25,000 \$50,000 \$75,000 \$100,000 \$125,000
 \$150,000 \$175,000 \$200,000 \$225,000 \$250,000

A. Monthly premium for one \$25,000 unit = \$ _____

B. Number of units of coverage X _____

C. Spouse's monthly premium (A x B) = \$ _____

*The amount of spouse coverage may not exceed the amount of Member coverage.

TOTAL MONTHLY COST: Your Premium \$ 3.25
Spouse Premium + \$ _____
Total Monthly Cost \$ 3.25

FAMILY LIFE INSURANCE COVERAGE

If applying for this coverage, please list your spouse and all unmarried dependent children under age 21, or age 25 if enrolled full-time in an accredited school. Specify relationship if other than your natural child.

NAME	DATE OF BIRTH	DEPENDENT'S RELATIONSHIP

INSURABILITY QUESTIONS: These questions pertain to **everyone** to be insured for life insurance coverage. (For South Carolina residents: Failure to completely and correctly answer the questions below may result in coverage being contested from its effective date).

Applicant's Height 5' 10" Weight 210 Spouse's Height _____ Weight _____
 (if applying for family life insurance coverage)

Child's Name, Height and Weight _____
 (if applying for family life insurance coverage)

	Yourself		Dependents	
1. Has any person to be insured ever had or been treated for cancer, heart or circulatory trouble, high blood pressure, diabetes, psychiatric conditions, neurological impairment, disorders of the kidney, liver, gastrointestinal system or blood, respiratory disorders, alcohol or drug abuse, Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the antibodies to the HIV virus?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Yes	No
2. Currently, or during the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized, had an operation or been under any kind of prescribed medication?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Yes	No
3. In the past 5 years, has any person to be insured been convicted of 2 or more moving violations, or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Yes	No
Driver's License No./State _____				
4. In the past 5 years, has any person to be insured engaged in: ballooning, cave exploration, parachuting, hang gliding, vehicle racing, scuba diving, mountain climbing or made any flight other than as a passenger?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Yes	No

If the answer to any of the above questions is "Yes", give complete details below. (If necessary, use a separate sheet of paper and attach it to the application.)

Name of Person	Illness or Condition — Date of Onset — Duration — Treatment — Operations — Medication — Degree of Recovery and Date	Name and address of Physician or other Practitioners and Hospitals where confined or treated

I designate as my BENEFICIARY (List full given name; i.e., Mary L. Smith, not Mrs. John Smith.)

Primary Beneficiary Jane Doe Relationship Sister

Contingent Beneficiary _____ Relationship _____
 (If primary beneficiary does not survive me)

Continued on next page....

NAME John A Doe SSN 123-56-7898
(Please Print) First Middle Last

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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maryland: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

For residents of 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 include imprisonment, fines, and denial of insurance benefits.

For residents of 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 state law.

For residents of 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

I understand that rates are based on current age on effective date of coverage and apply for the first twelve months, excluding age group changes. Although rates have not changed in the past, the rates can be changed in any year after issuance of coverage. Group premium rates may be increased but only if they are increased for all insureds of the same risk class and coverage category. It will be necessary for you to increase your premium payment when premiums increase. If you fail to pay the increase in premium, your coverage will be continued, but in a reduced amount.

I agree that coverage will not become effective for me or my dependents until the first day of the month coincident with or next following both (a) approval by Government Personnel Mutual Life Insurance Company of this application for insurance and (b) receipt by MBA of the required premium, unless I requested immediate coverage on the application and it is approved by Government Personnel Mutual Life Insurance Company. I understand that if I am under medical care requiring absence from regular duties or full-time employment, or normal activities on the scheduled effective date, the insurance will not become effective until the day after completion of the next day of regular duties or full-time employment or normal activities, and that if my dependent is confined in a hospital or other institution for medical care or treatment on the date he or she would otherwise become insured, insurance will not become effective until the day following his or her release from the hospital or other institution.

No sales agent or broker may make or modify the insurance contract or waive any requirement for coverage. Only an officer of Government Personnel Mutual Life Insurance Company can do these things.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: I authorize any medical practitioner, hospital, clinic, mental health facility, facility for the treatment of alcohol, drug abuse, or AIDS, Veteran's Administration hospital, other medically related facility, employer, insurer or its agent, reinsurer, the Medical Information Bureau, Inc. (MIB), government or law enforcement unit, consumer reporting agency, or the Department of Motor Vehicles having information as to the mental or physical

health, occupation, avocation, other insurance, character, habits, driving record, finances, or age of me or my minor children, to give such information to Government Personnel Mutual Life Insurance company or its reinsurer(s) at any time, including after my death. I further authorize all said sources, except Medical Information Bureau, Inc., to give such information to any agent or insurance support organization acting for Government Personnel Mutual Life Insurance Company or its reinsurer(s).

Any information obtained will be used to determine eligibility for insurance coverage and benefits, and may be released by Government Personnel Mutual Life Insurance Company to its reinsurer(s), the Medical Information Bureau, Inc. in connection with my application or claim, or as may be otherwise lawfully required.

I agree that a photocopy of this form will be as valid as the original. I also agree that this form will be valid for (1) 24 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, or (2) the duration of a claim for benefits. (For Virginia residents: I agree that this form will remain valid for 30 months from the date signed in connection with an application for issuance, reinstatement, or change of an insurance policy, and for the duration of a claim for benefits.) I know that I, or a person authorized to act for me, may obtain a copy of this form. I acknowledge receipt of notices entitled "Information Practices," "Investigative Consumer Reports," and "Medical Information Bureau, Inc." from Government Personnel Mutual Life Insurance Company.

Do you now have any life insurance or annuity contract? ___ Yes No.

Is the insurance applied for intended to replace any existing insurance or annuity contract? ___ Yes No.

By my signature below, I attest that the answers and statements, each of which I have made and read, are complete and true and shall form the basis for the issuance of insurance.

signature submitted electronically Anytown2, AL 10/01/2009
Signature of APPLICANT Signed At (City/State) Date

Signature of the SPOUSE Signed At (City/State) Date

If you made any corrections on this form, please initial each correction. Please make check or money order payable to: MBA
Send the application to: MILITARY BENEFIT ASSOCIATION, 14605 Avion Parkway, P.O. Box 221110, Chantilly, VA 20153-1110

MBA_247-A_90_(1009) (1009) web

FIELD UNDERWRITER (F.U.) SECTION (if applicable)

I HEREBY CERTIFY that the answers given to the foregoing questions in 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, the Federal Fair Credit Reporting Act, and Medical Information Bureau, Inc. were given to the Primary Proposed Insured.

To the best of your knowledge, a) has the applicant any existing life insurance or annuity contract? ___ Yes ___ No. b) is any insurance or annuity in this or any other company being replaced as a result of this application? ___ Yes ___ No. If either answer is "Yes", F.U. must attach completed replacement form(s) required by your state.

Agent Signature _____ Agent License # _____
F.U. Name _____ Agency/Marketing Director Code # _____
F.U. Code # _____ Agency Name/Telephone # _____

MBA_247-A_90_(1009) (1009) web



MILITARY BENEFIT ASSOCIATION

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

www.militarybenefit.org



*This coverage is underwritten by
Government Personnel Mutual Life Insurance
Company (GPM) under policy number GP01.
Not available in all states.*

www.gpmlife.com

Term 90 Insurance Application - Microsoft Internet Explorer provided by GPM Life Insurance Company

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites

Address <https://dev.www.militarybenefit.org/ApplyNow/Wizard/index.cfm?FORM=MBA%5F247%2DA%5F90%5F%281103%28> Go Links

Term 90 Active/Retired Military Member Insurance Application

Estimated premium **\$0.00**

Welcome!



Hi, my name is Debbie. I am your virtual agent and will be assisting you throughout our automated application process. Military Benefit Association uses advanced cryptography to protect your personal information. You can confirm cryptography is enabled and operational and review our security certification by looking for the lock icon at the bottom corner of your web browser.

Of course, if you prefer, you can still do business with us the old fashioned way by calling 1-800-336-0100 or via e-mail or postal mail. Our goal is to make the application process as straight-forward and convenient as possible.

I need to confirm your eligibility for this coverage before we can start the interview process.

Please confirm the following statements by checking the box next to each.

- I will be able to provide MBA a copy of proof of eligibility if needed. This will be either a copy of a recent Leave and Earnings Statement, a letter from my commanding officer OR something comparable proving my military status.
- I have my social security number (spouse SSN also required if married and applying for joint coverage).

At the end of the interview, you will be asked to review and electronically sign your application forms. You will be given an opportunity to print each of these documents for your records.

We appreciate the opportunity to serve your insurance needs.

MBAVP-A VAg1 (0509) Continue

Current mailing address

Street number and name

 (1234 Main St.)

(1 item remaining) Downloading picture <https://dev.www.militarybenefit.org/scripts/jquery> Unknown Zone

start Info... Inb... Sess... PCGLP Sess... Ter... Desktop My Computer 5:00 PM

Term 90 Insurance Application - Microsoft Internet Explorer provided by GPM Life Insurance Company

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites

Address: https://dev.www.militarybenefit.org/ApplyNow/Wizard/index.cfm?FORM=MBA%5F247%2DA%5F90%5F%281103%...

Date of birth: 10/01/1974 (mm/dd/yyyy)
Social Security Number (SSN): 123-56-7898 (xxx-xx-xxxx)
Height: 5' 10" (5' 10")
Weight: 210 (lbs)

Have you used any tobacco products during the past 12 months?
 Yes No

Service information

Branch of service:
 Air Force
 Marine Corps

Rank/Title: COL

Duty Status:
 Full-Time Active Duty
 Academy Cadet
 Separated from military

Date expected to retire or separate: 11/01/2012 (mm/dd/yyyy)
Unit assignment: US AIR CORP (If none, mail or fax copy of Reserve orders)

Requested coverage

Coverage Amount:
 \$50,000 \$100,000 \$150,000 \$200,000 \$250,000

Primary beneficiary: _____ Relationship: _____

Advice from your virtual agent...



If you elect a minimum of 2 units (\$100,000) on your life, each child may be covered, AT NO EXTRA COST, for \$2,500 per unit you purchased on your life.

Child coverage is \$500 per unit at age 14 days to 6 months, then \$2,500 per unit to age 21, or age 25 if a full-time student at an accredited school.

A maximum of \$12,500 is available for each child.

MBAVP-A VAgT3 (0509)

Term 90 Insurance Application - Microsoft Internet Explorer provided by GPM Life Insurance Company

File Edit View Favorites Tools Help

Address: https://dev.www.militarybenefit.org/ApplyNow/Wizard/index.cfm?FORM=MBA%5F247%2DA%5F90%5F%281103%...

Military Benefit Association offers a number of convenient ways to pay your premium. Please choose a payment method and complete the required fields.

Payment options

How would you like to pay your premium?

- Allotment deducted directly from my military or government paycheck.
- Electronic Funds Transfer (EFT) directly from my personal checking account.
- VISA, Master Card or Discover credit/debit card to be charged automatically on a recurring schedule.
- Check or Money Order. You will have to pay your premium due notices four to six weeks prior to premium being due.

Credit/debit card information

Name on card: John A Doe

Billing address: 1234 Main St. (1234 Main St.)

City: Anytown

Credit card number: 8654-3221-5685-4984 (xxxx-xxxx-xxxx-xxxx)

Expiration date: 12/2012 (mm/yyyy)

Please verify your account number.

I want future premiums to be billed:

- Quarterly
- Semi-annually
- Annually

I request immediate coverage FOLLOWING APPROVAL and authorize the first deduction on that date.

Important information

 Coverage normally begins on the next regular billing cycle following approval of your application.

To receive immediate coverage, you are authorizing automatic payment of your first premium immediately following approval rather than waiting for the next monthly billing cycle.

MBAYP-A VAgTCC(0509) AL

OK

Done

start 2009-Electronic ... Pop-Up boxes Term 90 Member ... Term 90 Insuran... Desktop My Computer 3:48 PM

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant Spouse **Family** Health Other Payment Review

Please review your completed forms and provide an electronic signature to submit your application. Take your time and review these documents thoroughly. By electronically signing them, you will be entering into a legally binding agreement with Military Benefit Association. You should save or print a copy of each of these forms for your records.

The information you've entered during the interview process will be available until you close your web browser or navigate away from this page. If you need to make corrections to any of your answers, simply click the appropriate tab, make the desired changes and return to the review tab to preview the changed documents.

Application Forms

Brochure and Application

I have taken all the information you provided and completed the application form for you. Please read your completed application from start to finish as it contains the full details of your agreement with Military Benefit Association.



Applicant Health-Related Information Release

This form authorizes the release of your medical records, if necessary, from your care providers for the purpose of determining insurability and is required by federal law.



Spouse Health-Related Information Release

This form authorizes the release of your spouse's medical records, if necessary, from your care providers for the purpose of determining insurability and is required by federal law if spouse coverage is requested.



Signature

You must answer the following questions to electronically sign these forms.

City where this application is being completed

Anytown1

State where this application is being completed Your initials

AL

JAD

JAD

MBA_247-A_90_(1009)

SUBMIT MY APPLICATION

Revised signature section by deleting "Please enter the city into this box where this application is being completed. Please enter the state into this box where this application is being completed. You must enter your initials to electronically sign these forms. Please enter "JAD" into this box before submitting this form:" and replacing it with the above language.

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant

Spouse

Family

Health

Other

Payment

Review

Please review your completed forms and provide an electronic signature to submit your application. Take your time and review these documents thoroughly. By electronically signing them, you will be entering into a legally binding agreement with Military Benefit Association. You should save or print a copy of each of these forms for your records.

The information you've entered during the interview process will be available until you close your web browser or navigate away from this page. If you need to make corrections to any of your answers, simply click the appropriate tab, make the desired changes and return to the review tab to preview the changed documents.

Application Forms

Brochure and Application

I have taken all the information you provided and completed the application form for you. Please read your completed application from start to finish as it contains the full details of your agreement with Military Benefit Association.



Applicant Health-Related Information Release

This form authorizes the release of your medical records, if necessary, from your care providers for the purpose of determining insurability and is required by federal law.



Signature

You must answer the following questions to electronically sign these forms.

City where this application is being completed

State where this application is being completed Your initials

MBA_247-A_90_(1009)

Revised signature section by deleting "Please enter the city into this box where this application is being completed. Please enter the state into this box where this application is being completed. You must enter your initials to electronically sign these forms. Please enter "JAD" into this box before submitting this form:" and replacing it with the above language.

SERFF Tracking Number: FRCS-126375333 State: Arkansas
 Filing Company: Government Personnel Mutual Life Insurance State Tracking Number: 44089
 Company
 Company Tracking Number: 5260
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: MBA Term 90 App (MBA_247-A_90)
 Project Name/Number: GPM/68/68

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/12/2009	Supporting Document	John Doe screenprints of application MBA_247-A_90_(1009)	01/05/2010	Term 90 married - web shots.pdf (Superceded) Term 90 single - web shots.pdf (Superceded)

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant	Spouse	Family	Health	Other	Payment	Review
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Let's get started by collecting information about you, the applicant. This form will adjust dynamically as you respond to each question in order to alert you to input errors and hide questions that are not relevant to your application.

Current coverage

Please select the option that best describes your current relationship with MBA.

- I am a new member.
- I am requesting additional coverage.
- I am requesting a change in coverage.

Contact information

First name John	Middle initial A	Last name Doe
Home phone 2103572222	Work phone 2103572222	Alternate phone 2103572222
E-mail address jdoe@yahoo.com		

Current mailing address

Street number and name
1234 Main St.
(1234 Main St.)

City
Anytown

State
AL

Zip
12356-4565

Permanent home address (Address from which mail will always be forwarded to you)

Street number and name
1234 Main St.
(1234 Main St.)

City
Anytown

State
AL

Zip
12356-4565

Personal information

Sex <input checked="" type="radio"/> Male <input type="radio"/> Female	Marital status <input type="radio"/> Single <input checked="" type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Legally Separated
Date of birth 10/01/1974 (mm/dd/yyyy)	Social Security Number (SSN) 123-56-7898 (xxx-xx-xxxx)
Height 5' 10" (5' 10")	Weight 210 (lbs)

Have you used any tobacco products during the past 12 months?

Yes No

Service information

Branch of service

- Air Force Army Coast Guard
 Marine Corps Navy

Rank/Title

COL

Duty Status

- Full-Time Active Duty Retired National Guard
 Academy Cadet Ready Reserve ROTC
 Separated from military

Date expected to retire or separate

11/01/2012
(mm/dd/yyyy)

Unit assignment

US AIR CORP
(If none, mail or fax copy of Reserve orders)

Requested coverage

Coverage Amount

- \$50,000 \$100,000 \$150,000 \$200,000 \$250,000

Primary beneficiary

Jane Doe
(full given name; i.e., Mary L. Smith, not Mrs. John Smith)

Relationship

Wife

Contingent beneficiary

(if primary beneficiary does not survive me)

Relationship

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant

Spouse

Family

Health

Other

Payment

Review

Please provide information about your spouse. Note that spouse coverage limits are based on your applicant coverage selection. For additional coverage options return to the applicant tab and increase your coverage.

A spouse may NOT be insured as a dependent if he or she is insured as a Member of MBA.

Coverage

Spouse's coverage amount

- \$25,000
 \$50,000
 \$75,000
 \$100,000
 \$125,000
 \$150,000
 \$175,000
 \$200,000
 \$225,000
 \$250,000
 None

Personal information

Name

Jane Doe

Date of birth

10/26/1976

(mm/dd/yyyy)

Social Security Number (SSN)

232-65-4654

(xxx-xx-xxxx)

Height

5' 7"

(5' 7")

Weight

180

(lbs)

Has your spouse used any tobacco products during the past 12 months?

- Yes
 No

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant

Spouse

Family

Health

Other

Payment

Review

Health information

Has any person to be insured ever had or been treated for cancer, heart or circulatory trouble, high blood pressure, diabetes, psychiatric conditions, neurological impairment, disorders of the kidney, liver, gastrointestinal system or blood, respiratory disorders, alcohol or drug abuse, Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the antibodies to the HIV virus?

Yourself

 Yes No

Dependents

 Yes No

Currently, or during the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized, had an operation or been under any kind of prescribed medication?

Yourself

 Yes No

Dependents

 Yes No

In the past 5 years, has any person to be insured been convicted of 2 or more moving violations, or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked?

Yourself

 Yes No

Dependents

 Yes No

In the past 5 years, has any person to be insured engaged in: ballooning, cave exploration, parachuting, hang gliding, vehicle racing, scuba diving, mountain climbing or made any flight other than as a passenger?

Yourself

 Yes No

Dependents

 Yes No[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant

Spouse

Family

Health

Other

Payment

Review

Please tell us about any existing life insurance or annuity contracts you may hold.

Other Coverage

Do you now have any life insurance or annuity contract?

Yes No

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant

Spouse

Family

Health

Other

Payment

Review

Military Benefit Association offers a number of convenient ways to pay your premium. Please choose a payment method and complete the required fields.

Payment options

How would you like to pay your premium?

- Allotment deducted directly from my military or government paycheck.
- Electronic Funds Transfer (EFT) directly from my personal checking account.
- VISA, Master Card or Discover credit/debit card to be charged automatically on a recurring schedule.
- Check or Money Order. You will have the option to pay quarterly, semi-annually or annually and will receive premium due notices four to six weeks prior to premium being due.

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$4.90

Applicant

Spouse

Family

Health

Other

Payment

Review

Please review your completed forms and provide an electronic signature to submit your application. Take your time and review these documents thoroughly. By electronically signing them, you will be entering into a legally binding agreement with Military Benefit Association. You should save or print a copy of each of these forms for your records.

The information you've entered during the interview process will be available until you close your web browser or navigate away from this page. If you need to make corrections to any of your answers, simply click the appropriate tab, make the desired changes and return to the review tab to preview the changed documents.

Application Forms

Brochure and Application

I have taken all the information you provided and completed the application form for you. Please read your completed application from start to finish as it contains the full details of your agreement with Military Benefit Association.



Applicant Health-Related Information Release

This form authorizes the release of your medical records, if necessary, from your care providers for the purpose of determining insurability and is required by federal law.



Spouse Health-Related Information Release

This form authorizes the release of your spouse's medical records, if necessary, from your care providers for the purpose of determining insurability and is required by federal law if spouse coverage is requested.



Signature

Please enter the city into this box where this application is being completed:

Please enter the state into this box where this application is being completed:

You must enter your initials to electronically sign these forms.

Please enter "JAD" into this box before submitting this form:

[MBA_247-A_90_\(1009\)](#)

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant Spouse Family Health Other Payment Review

Let's get started by collecting information about you, the applicant. This form will adjust dynamically as you respond to each question in order to alert you to input errors and hide questions that are not relevant to your application.

Current coverage

Please select the option that best describes your current relationship with MBA.

- I am a new member.
- I am requesting additional coverage.
- I am requesting a change in coverage.

Contact information

First name Middle initial Last name

Home phone Work phone Alternate phone

E-mail address

Current mailing address

Street number and name
(1234 Main St.)

City State Zip

Permanent home address (Address from which mail will always be forwarded to you)

Street number and name
(1234 Main St.)

City State Zip

Personal information

Sex Male Female Marital status Single Married Divorced Legally Separated

Date of birth Social Security Number (SSN)
(mm/dd/yyyy) (xxx-xx-xxxx)

Height Weight
(5' 10") (lbs)

Have you used any tobacco products during the past 12 months?

Yes No

Service information

Branch of service

Air Force Army Coast Guard

Marine Corps Navy

Rank/Title

COL

Duty Status

Full-Time Active Duty Retired National Guard

Academy Cadet Ready Reserve ROTC

Separated from military

Date expected to retire or separate

11/01/2012

(mm/dd/yyyy)

Unit assignment

US AIR CORP

(If none, mail or fax copy of Reserve orders)

Requested coverage

Coverage Amount

\$50,000 \$100,000 \$150,000 \$200,000 \$250,000

Primary beneficiary

Jane Doe

(full given name; i.e., Mary L. Smith, not Mrs. John Smith)

Relationship

Sister

Contingent beneficiary

(if primary beneficiary does not survive me)

Relationship

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant

Spouse

Family

Health

Other

Payment

Review

Health information

Has any person to be insured ever had or been treated for cancer, heart or circulatory trouble, high blood pressure, diabetes, psychiatric conditions, neurological impairment, disorders of the kidney, liver, gastrointestinal system or blood, respiratory disorders, alcohol or drug abuse, Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the antibodies to the HIV virus?

Yes No

Currently, or during the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized, had an operation or been under any kind of prescribed medication?

Yes No

In the past 5 years, has any person to be insured been convicted of 2 or more moving violations, or driving under the influence of drugs or alcohol, or had a driver's license suspended or revoked?

Yes No

In the past 5 years, has any person to be insured engaged in: ballooning, cave exploration, parachuting, hang gliding, vehicle racing, scuba diving, mountain climbing or made any flight other than as a passenger?

Yes No

[MBA_247-A_90_\(1009\)](#)

CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant

Spouse

Family

Health

Other

Payment

Review

Please tell us about any existing life insurance or annuity contracts you may hold.

Other Coverage

Do you now have any life insurance or annuity contract?

Yes No

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CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant

Spouse

Family

Health

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Payment

Review

Military Benefit Association offers a number of convenient ways to pay your premium. Please choose a payment method and complete the required fields.

Payment options

How would you like to pay your premium?

- Allotment deducted directly from my military or government paycheck.
- Electronic Funds Transfer (EFT) directly from my personal checking account.
- VISA, Master Card or Discover credit/debit card to be charged automatically on a recurring schedule.
- Check or Money Order. You will have the option to pay quarterly, semi-annually or annually and will receive premium due notices four to six weeks prior to premium being due.

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CONTINUE >>

Term 90 Active/Retired Military Member Insurance Application

Estimated premium

\$3.25

Applicant

Spouse

Family

Health

Other

Payment

Review

Please review your completed forms and provide an electronic signature to submit your application. Take your time and review these documents thoroughly. By electronically signing them, you will be entering into a legally binding agreement with Military Benefit Association. You should save or print a copy of each of these forms for your records.

The information you've entered during the interview process will be available until you close your web browser or navigate away from this page. If you need to make corrections to any of your answers, simply click the appropriate tab, make the desired changes and return to the review tab to preview the changed documents.

Application Forms

Brochure and Application

I have taken all the information you provided and completed the application form for you. Please read your completed application from start to finish as it contains the full details of your agreement with Military Benefit Association.



Applicant Health-Related Information Release

This form authorizes the release of your medical records, if necessary, from your care providers for the purpose of determining insurability and is required by federal law.



Signature

Please enter the city into this box where this application is being completed:

Please enter the state into this box where this application is being completed:

You must enter your initials to electronically sign these forms.

Please enter "JAD" into this box before submitting this form:

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