

SERFF Tracking Number: FRCS-126612864 State: Arkansas
Filing Company: Government Personnel Mutual Life Insurance Company State Tracking Number: 45592
Company Tracking Number: 5364
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: MBA Electronic apps MBA_248-A_90_(0310) and MBA_249-A_90_(0310)
Project Name/Number: GPM/69/69

Filing at a Glance

Company: Government Personnel Mutual Life Insurance Company

Product Name: MBA Electronic apps MBA_248-SERFF Tr Num: FRCS-126612864 State: Arkansas
A_90_(0310) and MBA_249-A_90_(0310)

TOI: L04G Group Life - Term

SERFF Status: Closed-Approved-
Closed State Tr Num: 45592

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

Co Tr Num: 5364

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Bob Motley, Aaron Clark

Disposition Date: 06/25/2010

Date Submitted: 05/05/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: GPM/69

Project Number: 69

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/25/2010

Deemer Date:

Submitted By: Bob Motley

Filing Description:

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

Our fee of \$100 has been sent by EFT on this same date.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Submitted to the
domicile state on or about this same date.

Market Type: Group

Group Market Size: Large

Group Market Type: Association

Explanation for Other Group Market Type:

State Status Changed: 05/06/2010

Created By: Aaron Clark

Corresponding Filing Tracking Number:

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These are applications for a group term product used by members of the Military Benefit Association, located in Chantilly, VA. Form MBA_248-A_90_(0310) will be used for a sponsored spouse applying for the MBA Term 90 plan, and form MBA_249-A_90_(0310) will be used for U.S. government civilian employees. These applications are similar to application MBA_247-A_90_(1009), which was approved by your Department on 07/12/2004. A copy showing the changes made to these applications is attached for your information.

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) a John Doe screen-print of application MBA_248-A_90_(0310), showing all possible screens; 2) a John Doe copy of application MBA-248-A-90-(0310) as it would appear attached to the certificate; 3) John Doe screen-prints of application MBA_249-A_90_(0310) showing all possible screens, one for married and one for singles; 4) John Doe copies of MBA_249-A_90_(0310), one for married and one for singles, as they would appear attached to the certificate; and 5) screen prints of the pop-up boxes for both application MBA_248-A_90_(0310) and MBA_249-A_90_(0310).

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

SERFF Tracking Number: FRCS-126612864 State: Arkansas
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Project Name/Number: GPM/69/69

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

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: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form times two form equals \$100.00.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Government Personnel Mutual Life Insurance Company	\$100.00	05/05/2010	36253670

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/25/2010	06/25/2010
Approved-Closed	Linda Bird	05/06/2010	05/06/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	John Doe applications	Aaron Clark	06/24/2010	06/24/2010
Form	Life Insurance Application (for U.S. Government Civilian Employees)	Aaron Clark	06/24/2010	06/24/2010
Supporting Document	John Doe applications	Aaron Clark	06/24/2010	06/24/2010
Supporting Document	Marked copy	Aaron Clark	06/24/2010	06/24/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to reopen	Note To Filer	Linda Bird	06/22/2010	06/22/2010
Request to reopen	Note To Reviewer	Aaron Clark	06/21/2010	06/21/2010

SERFF Tracking Number: FRCS-126612864 *State:* Arkansas
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Project Name/Number: GPM/69/69

Disposition

Disposition Date: 06/25/2010

Implementation Date:

Status: Approved-Closed

Comment: Company has submitted corrected application to replace the previously approved application.

Rate data does NOT apply to filing.

SERFF Tracking Number: FRCS-126612864 State: Arkansas
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 Project Name/Number: GPM/69/69

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document (revised)	John Doe applications		Yes
Supporting Document	John Doe applications	Replaced	Yes
Supporting Document	John Doe applications	Replaced	Yes
Supporting Document	Screen prints of applications		Yes
Supporting Document	Pop up boxes of applications		Yes
Supporting Document	Redline version of forms		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Certification of Compliance		Yes
Supporting Document	Authorization		Yes
Supporting Document	Marked copy		Yes
Form	Life Insurance Application (for Sponsored Spouse Members)		Yes
Form (revised)	Life Insurance Application (for U.S. Government Civilian Employees)		Yes
Form	Life Insurance Application (for U.S. Government Civilian Employees)	Replaced	Yes

SERFF Tracking Number: FRCS-126612864 *State:* Arkansas
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Disposition

Disposition Date: 05/06/2010

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		Yes
Supporting Document (revised)	John Doe applications		Yes
Supporting Document	John Doe applications	Replaced	Yes
Supporting Document	John Doe applications	Replaced	Yes
Supporting Document	Screen prints of applications		Yes
Supporting Document	Pop up boxes of applications		Yes
Supporting Document	Redline version of forms		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Certification of Compliance		Yes
Supporting Document	Authorization		Yes
Supporting Document	Marked copy		Yes
Form	Life Insurance Application (for Sponsored Spouse Members)		Yes
Form (revised)	Life Insurance Application (for U.S. Government Civilian Employees)		Yes
Form	Life Insurance Application (for U.S. Government Civilian Employees)	Replaced	Yes

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Project Name/Number: GPM/69/69

Amendment Letter

Submitted Date: 06/24/2010

Comments:

On behalf of Government Personnel Mutual Life Insurance Company, we offer the following.

We inadvertently submitted the wrong John doe applications in our amendment that was submitted to your department on 06/24/2010. We are now attaching the correct john doe applications.

We applogize for the error.

If you have any questions or need additional information, 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 applications

Comment:

MBA_248-A_90_(0310) Spouse John Doe DIST.pdf
app MBA_249-A_90_(0310) - revised cert JDoe Married.pdf
app MBA_249-A_90_(0310) - revised cert JDoe Single.pdf

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 Project Name/Number: GPM/69/69

Amendment Letter

Submitted Date: 06/24/2010

Comments:

Thank you for reopening the filing.

Subsequent to submitting the filing, the Company noticed errors in the application on page 1. They would like to substitute the previously submitted MBA_249-A_90_(0310), which was approved by your Department on 05/06/2010, with the revised application attached in this submission. Changes are described below.

The previous application form MBA_249-A_90_(0310) inadvertently had the option of paying by military allotment which is not valid for civilian government applicants. This option has been deleted. The rest of this paragraph was moved.

The Company also replaced "Current Mailing Address" with "Home Address" and changed "Permanent Home Address" to "Business Address". They also moved "(Address from which mail will always be forwarded to you.)" so that it would clarify "Home Address".

All of these changes are on page 1 in the first column. A revised application form and a marked copy of page 1 are attached.

In addition, we have also revised the informational John Doe examples of MBA_249-A_90_(0310), one for married and one for singles, as they would appear attached to the certificate. The revised examples reflect the changes made to the application form.

This application has not yet been used in the state; therefore, the Company would like to use the same form number.

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:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action	Previous Filing #	Replaced Form #	Readability Score	Attachments
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 Project Name/Number: GPM/69/69

Other

MBA_249- Application/ELife	Initial	52.000	app
A_90_(0310)nrollment	Insurance		MBA_249-
Form	Application		A_90_(0310) -
	(for U.S.		Revised.pdf
	Government		
	Civilian		
	Employees)		

Supporting Document Schedule Item Changes:

User Added -Name: John Doe applications

Comment:

MBA_248-A_90_(0310) Spouse John Doe DIST.pdf
 app MBA_249-A_90_(0610) revised Cert JDoe Married.pdf
 app MBA_249-A_90_(0610) revised Cert JDoe Single.pdf

User Added -Name: Marked copy

Comment:

app MBA_249-A_90_(0310) Marked Copy Page 1.pdf

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Project Name/Number: GPM/69/69

Note To Filer

Created By:

Linda Bird on 06/22/2010 09:53 AM

Last Edited By:

Linda Bird

Submitted On:

06/22/2010 09:53 AM

Subject:

Request to reopen

Comments:

Filing has been reopened in order for correction to be made in the application on page 1.

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Project Name/Number: GPM/69/69

Note To Reviewer

Created By:

Aaron Clark on 06/21/2010 03:53 PM

Last Edited By:

Aaron Clark

Submitted On:

06/21/2010 04:19 PM

Subject:

Request to reopen

Comments:

Subsequent to submitting the filing, the Company noticed errors in the application on page 1. Please note that the application MBA_249-A_90_(0310) has not yet been used in the state. Therefore, we ask that you reopen the filing so we may submit the corrected application to replace the approved application.

If you have any questions or concerns, then please feel free to contact me.

Thank you.

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Form Schedule

Lead Form Number: MBA_248-A_90_(0310)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	MBA_248-A_90_(0310)	Application/Enrollment Form	Life Insurance Application (for Sponsored Spouse Members)	Initial		52.000	MBA_248-A_90_(0310) DIST.pdf
	MBA_249-A_90_(0310)	Application/Enrollment Form	Life Insurance Application (for U.S. Government Civilian Employees)	Initial		52.000	app MBA_249-A_90_(0310) - Revised.pdf

MBA Term 90 Life Insurance Coverage

FOR SPONSORED SPOUSE MEMBERS

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 (MBA).

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

Current Mailing Address _____

 _____ Zip _____

Home Phone No. (_____) _____
 Work Phone No. (_____) _____
 Alternate Phone No. (_____) _____
 E-mail Address: _____
 Permanent Home Address (Address from which mail will always be forwarded to you).

 _____ Zip _____

PLEASE PROVIDE SPONSOR INFORMATION

SPONSOR'S Name _____

SPONSOR'S SSN _____

SPONSOR'S Status:

- a. An insured member of MBA
 b. Military
 Rank _____ Branch of Service _____
 Duty Status: (Check one)
 Full-Time Active Duty Retired
 National Guard Ready Reserve
 Date expected to retire or separate _____ / _____ / _____
Mo Day Yr

c. Full-time U.S. Government Civilian Employee.

SPONSOR'S unit or work assignment for purpose of verification:

 Telephone No. (_____) _____

CHECK ONE:

- New Member Coverage Addition Coverage Change

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.

I am enclosing with this application: (Check one)

- A copy of the military allotment authorization form. (I want my life insurance 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 _____ Yr / _____ Mo)
- 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.)

FAMILY LIFE INSURANCE COVERAGE

If applying for this coverage, please list 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	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 _____

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_248-A_90_(0310)

(0310) 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_248-A_90_(0310)

(0310) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

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_249-A_90_(0310)

(0310) 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_249-A_90_(0310)

(0310) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

SERFF Tracking Number: FRCS-126612864 State: Arkansas
 Filing Company: Government Personnel Mutual Life Insurance State Tracking Number: 45592
 Company
 Company Tracking Number: 5364
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: MBA Electronic apps MBA_248-A_90_(0310) and MBA_249-A_90_(0310)
 Project Name/Number: GPM/69/69

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR Read Cert dist.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: The application is attached under the form schedule.		

	Item Status:	Status Date:
Satisfied - Item: John Doe applications		
Comments:		
Attachments: MBA_248-A_90_(0310) Spouse John Doe DIST.pdf app MBA_249-A_90_(0310) - revised cert JDoe Married.pdf app MBA_249-A_90_(0310) - revised cert JDoe Single.pdf		

	Item Status:	Status Date:
Satisfied - Item: Screen prints of applications		
Comments:		
Attachments: MBA_248-A_90_(0310) Spouse online screen shots DIST.pdf MBA_249-A_90_(0310) Civilian online screen shots - married DIST.pdf MBA_249-A_90_(0310) Civilian online screen shots - single DIST.pdf		

SERFF Tracking Number: FRCS-126612864 State: Arkansas
 Filing Company: Government Personnel Mutual Life Insurance State Tracking Number: 45592
 Company
 Company Tracking Number: 5364
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: MBA Electronic apps MBA_248-A_90_(0310) and MBA_249-A_90_(0310)
 Project Name/Number: GPM/69/69

Item Status: **Status Date:**

Satisfied - Item: Pop up boxes of applications
Comments:
Attachments:
 MBA_248-A_90_(0310) Spouse popup boxes DIST.pdf
 MBA_249-A_90_(0310) Civilian popup boxes DIST.pdf

Item Status: **Status Date:**

Satisfied - Item: Redline version of forms
Comments:
Attachments:
 MBA_248-A_90_(0310) - Spouse redline DIST.pdf
 MBA_249-A_90_(0310) - Civilian redline DIST.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachments:
 SOV MBA-248-A 90 DIST.pdf
 SOV MBA-249-A 90 DIST.pdf

Item Status: **Status Date:**

Satisfied - Item: Certification of Compliance
Comments:
Attachment:
 AR COC dist.pdf

SERFF Tracking Number: FRCS-126612864 State: Arkansas
Filing Company: Government Personnel Mutual Life Insurance State Tracking Number: 45592
Company
Company Tracking Number: 5364
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: MBA Electronic apps MBA_248-A_90_(0310) and MBA_249-A_90_(0310)
Project Name/Number: GPM/69/69

Item Status: **Status**
Date:

Satisfied - Item: Authorization

Comments:

Attachment:

Authorization dist.pdf

Item Status: **Status**
Date:

Satisfied - Item: Marked copy

Comments:

Attachment:

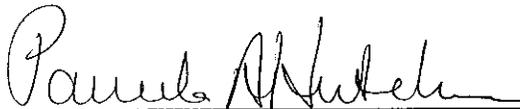
app MBA_249-A_90_(0310) Marked Copy Page 1.pdf

**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 248-A 90 (0310)	52
MBA 249-A 90 (0310)	52



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

May 3, 2010

Date

MBA Term 90 Life Insurance Coverage FOR SPONSORED SPOUSE MEMBERS

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 (MBA).

NAME John A Doe **SSN** 235-48-7988
(Please Print) First Middle Last

Actual Age 35 Date of Birth 04 / 02 / 1975
Mo Day Yr

- Male Married Divorced
 Female Single Legally Separated

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

Current Mailing Address

1234 Main St.
Anytown, AK Zip 12365-4568

Home Phone No. (210) 357-2222

Work Phone No. (210) 357-2222

Alternate Phone No. (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, AK Zip 12365-4568

PLEASE PROVIDE SPONSOR INFORMATION

SPONSOR'S Name Jane Doe

SPONSOR'S SSN 123-56-4879

SPONSOR'S Status:

- a. An insured member of MBA
 b. Military
 Rank MAJ Branch of Service Air Force
 Duty Status: (Check one)
 Full-Time Active Duty Retired
 National Guard Ready Reserve
 Date expected to retire or separate 05 / 01 / 2012
Mo Day Yr

- c. Full-time U.S. Government Civilian Employee.

SPONSOR'S unit or work assignment for purpose of verification:

USAF

Telephone No. (321) 565-7899

CHECK ONE:

- New Member Coverage Addition Coverage Change

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.

I am enclosing with this application: (Check one)

- A copy of the military allotment authorization form. (I want my life insurance 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 / /
Yr Mo)
 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.)

FAMILY LIFE INSURANCE COVERAGE

If applying for this coverage, please list 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	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 6' 1" Weight 180 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 Wife

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

Continued on next page....

NAME John A Doe SSN 235-48-7988
(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

Anytown, AK

04/05/2010

Signature of APPLICANT

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_248-A_90_(0310)

(0310) 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_248-A_90_(0310)

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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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

MBA Term 90 Life Insurance

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION APPLICATION FORM
Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)

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 (MBA).

NAME John A Doe **SSN** 235-48-7988
(Please Print) First Middle Last

Actual Age 35 Date of Birth 04 / 02 / 1975
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

Home Address (Address from which mail will always be forwarded to you.)
1234 Main St.
Anytown, AL Zip 12365-4568

Home Phone: 210-357-2222
Alternate Phone: 210-357-2222
Business Address _____

1234 Main St.
Anytown, AL Zip 12365-4568

Work Phone: 210-357-2222
E-mail Address: jdoe@yahoo.com

a. I am a U.S. Citizen: Yes No

b. I am a full-time civilian employee of the U.S. Government? Yes No

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

I am enclosing with this application: (Check one)

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 premium. 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 Coverage Addition Coverage Change

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

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

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	04-10-1975	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 6' 1" Weight 180 Spouse's Height 5' 7" Weight 150
 (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 235-48-7988
(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 Anytown, AL 04-21-2010
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_249-A_90_(0310) (0310) 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_249-A_90_(0310) (0310) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

MBA Term 90 Life Insurance

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION APPLICATION FORM
Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)

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 (MBA).

NAME John A Doe **SSN** 235-48-7988
(Please Print) First Middle Last

Actual Age 35 Date of Birth 04 / 02 / 1975
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

Home Address (Address from which mail will always be forwarded to you.)
1234 Main St.
Anytown, AL Zip 12365-4568

Home Phone: 210-357-2222
Alternate Phone: 210-357-2222
Business Address _____

1234 Main St.
Anytown, AL Zip 12365-4568

Work Phone: 210-357-2222
E-mail Address: jdoe@yahoo.com

a. I am a U.S. Citizen: Yes No

b. I am a full-time civilian employee of the U.S. Government? Yes No

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

I am enclosing with this application: (Check one)

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 premium. 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 Coverage Addition Coverage Change

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) = \$ _____

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

NAME John A Doe SSN 235-48-7988
 (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 6' 1" Weight 180 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 235-48-7988
(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 Anytown, AL 04-21-2010
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_249-A_90_(0310) (0310) 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_249-A_90_(0310) (0310) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

Term 90 Sponsored Spouse Insurance Application

Estimated premium

\$3.25

Applicant **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

Sponsor Information

Sponsor's name

Sponsor's SSN

(xxx-xx-xxxx)

Sponsor's status

 An insured member of MBA Active or retired military Full-time U.S. government civilian employee

Branch of service

 Air Force Army Coast Guard Marine Corps Navy

Rank/Title

Duty status

 Full-Time Active Duty Retired National Guard Ready Reserve

Sponsor's unit or work assignment for purpose of verification

Telephone No.

Date expected to retire or separate

(mm/dd/yyyy)

Requested coverage

Coverage Amount

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

Primary beneficiary

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

Relationship

Contingent beneficiary

(if primary beneficiary does not survive me)

Relationship

MBA_248-A_90_(0310)

Term 90 Sponsored Spouse Insurance Application

Estimated premium

\$3.25

Applicant **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_248-A_90_\(0310\)](#)

CONTINUE >>

Term 90 Sponsored Spouse Insurance Application

Estimated premium

\$3.25

Applicant 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_248-A_90_\(0310\)](#)

CONTINUE >>

Term 90 Sponsored Spouse Insurance Application

Estimated premium

\$3.25

Applicant **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 from my sponsor's military or government check.
- 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 or semi-annually and will receive premium due notices four to six weeks prior to premium being due.

Check or money order information

I want future premiums to be billed

- Quarterly Semi-annually

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

MBA_248-A_90_(0310)

CONTINUE >>

Term 90 Sponsored Spouse Insurance Application

Estimated premium

\$3.25

Applicant	Family	Health	Other	Payment	Review
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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_248-A_90_\(0310\)](#)

Term 90 U.S. Government Civilian Employee 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

Home address

Street number and name
(1234 Main St.)

City State Zip

Business address

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

Height
(5' 10") Weight
(lbs)

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

Yes No

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_249-A_90_\(0310\)](#)

CONTINUE >>

Term 90 U.S. Government Civilian Employee 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

04/10/1975

(mm/dd/yyyy)

Social Security Number (SSN)

123-56-4879

(xxx-xx-xxxx)

Height

5' 7"

(5' 7")

Weight

150

(lbs)

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

- Yes
 No

MBA_249-A_90_(0310)

CONTINUE >>

Term 90 U.S. Government Civilian Employee 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_249-A_90_\(0310\)](#)

CONTINUE >>

Term 90 U.S. Government Civilian Employee 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_249-A_90_\(0310\)](#)

CONTINUE >>

Term 90 U.S. Government Civilian Employee 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?

- 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 or semi-annually and will receive premium due notices four to six weeks prior to premium being due.

Check or money order information

I want future premiums to be billed

- Quarterly Semi-annually

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

MBA_249-A_90_(0310)

CONTINUE >>

Term 90 U.S. Government Civilian Employee Insurance Application

Estimated premium

\$4.90

Applicant	Spouse	Family	Health	Other	Payment	Review
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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_249-A_90_\(0310\)](#)

Term 90 U.S. Government Civilian Employee 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

Home address

Street number and name
(1234 Main St.)

City State Zip

Business address

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

Height
(5' 10") Weight
(lbs)

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

Yes No

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_249-A_90_\(0310\)](#)

CONTINUE >>

Term 90 U.S. Government Civilian Employee 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_249-A_90_\(0310\)](#)

CONTINUE >>

Term 90 U.S. Government Civilian Employee 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_249-A_90_\(0310\)](#)

CONTINUE >>

Term 90 U.S. Government Civilian Employee 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?

- 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 or semi-annually and will receive premium due notices four to six weeks prior to premium being due.

Check or money order information

I want future premiums to be billed

- Quarterly Semi-annually

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

MBA_249-A_90_(0310)

CONTINUE >>

Term 90 U.S. Government Civilian Employee 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.

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Application Forms

Brochure and Application

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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

AL

JAD

MBA_249-A_90_(0310)

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_248-A_90_%280310%29&residence=AI Go Links

Term 90 Sponsored Spouse 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.

Current mailing address

Please select your current mailing address:

- I am currently living at this address.
- I am currently living at a different address.
- I am currently living at a different address.

Contact information

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.

E-mail address: MBAL3S-A gt1 (0310)

Current mailing address

Street number and name
(1234 Main St.)

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_248-A_90_%280310%29&residence=AI Go Links

An insured member of MBA Active or retired military Full-time U.S. government civilian employee

Branch of service

Air Force Army Coast Guard

Marine Corps Navy

Rank/Title
MAJ

Duty status

Full-Time Active Duty Ready Reserve

Sponsor's unit or work assignment for purchase
USAF

Date expected to retire or separate
05/01/2012
(mm/dd/yyyy)

Requested coverage

Coverage Amount

\$50,000 \$100,000

Primary beneficiary

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

Contingent beneficiary Relationship

(if primary beneficiary does not survive me)

MBA_248-A_90_(0310)

CONTINUE >>

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 VAg3 (0509)

OK

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_248-A_90_%280310%29&residence=At Go Links

Term 90 Sponsored Spouse Insurance Application

Estimated premium **\$3.25**

Applicant Family Health Other Payment Review

Let's get started by collecting information... each question in order to alert you to input errors and hide questions that are not applicable to you.

Advice from your virtual agent...



If you already have an account with MBA, simply login using your e-mail address and password and I'll complete most of the fields on this form for you.

MBAVP-A VAg2 (0509)

Current coverage

Please select the option that best describes you:

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

Contact information

First name:

Home phone: Work phone: Alternate phone:

E-mail address:

Current mailing address

Street number and name:
(1234 Main St.)

Done

start Inf... 20... Se... MB... RE... Te... Po... Desktop My Computer 8:55 AM

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_248-A_90_%280310%29&residence=At Go Links

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 or semi-annually and will receive premium due notices four to six weeks prior to premium being due.

Checking account information

Each month, MBA will debit your personal checking account for the amount due for your premium payment. All you have to do is record the debit in your check register on the fifth of each month. The debit will appear on your monthly statement from your bank.

You may transfer your account to a different bank or another branch of the same bank at any time. Just give us a few weeks notice so we can send you a new EFT authorization and process the paperwork.

If there are insufficient funds in your account to cover the amount of the automatic debit on if the debit is initiated from your account, your life insurance may lapse and your EFT privilege may be revoked.

This service is available only for United States residents.

To take advantage of EFT, you will need to provide the name and address of your financial institution and routing/transit number.

Name and address of financial institution

(First Credit Union, 1234 Main St., Anytown, VA 22111)

Routing/transit number (first 9 digits from check)

(if your checking account is through a credit union, please contact them for this number)

Checking account number

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.

You will need to send a check or money order for your first three months premiums to obtain immediate coverage following approval when paying by electronic funds transfer.

OK

Association, 14605 Avion Parkway,

Done Internet

start Inf... 20... Se... MB... RE... Te... Po... Desktop My Computer 9:00 AM

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_248-A_90_%280310%29&residence=At Go Links

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 from my sponsor's military or government check.
- 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 or semi-annually and will receive 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

State
AK

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

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.

MBAVP-A VAgTCC(0509) OK

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_248-A_90_%280310%29&residence=At Go Links

Let's get started by collecting information... each question in order to alert you to

Current coverage
Please select the option that best describes you.

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

Contact information

First name: John
Home phone: 210-357-2222
Work phone: 210-357-2222
Alternate phone: 210-357-2222
E-mail address: jdoe@yahoo.com

Current mailing address

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

City: Anytown
State: AK
Zip:
This field is required.

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

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

City: _____ State: _____ Zip: _____

Oops!



There are several minor issues we need to address before we can continue.

I have marked the problem fields with red text indicating why the field is invalid and how to correct it.

Please make the required corrections and press the continue button again.

MBAVP-A VAgtE (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_249-A_90_%280310%29&residence=Al Go Links

Term 90 U.S. Government Civilian Employee 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 am a citizen of the United States of America.
- I am a full-time civilian employee of the United States Government
- 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.

Continue

Applicant

Let's get started
input error

Current coverage
Please select

- I am a...
- I am a...
- I am a...

Contact information

First name

Home phone

E-mail address
MBAL3G-A gt1 (0310)

Home address

Street number and name
(1234 Main St.)

Done Internet

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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_249-A_90_%280310%29&residence=AL Go Links

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

City State Zip
Anytown AL 12365-4568

Business address

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

City
Anytown

Personal information

Sex
 Male Female

Date of birth
04/02/1975
(mm/dd/yyyy)

Height
6' 1"
(5' 10")

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

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 \(0509\)](#)

OK

Done Internet

start I... D... S... M... R... T... R... D... Desktop My Computer 2:10 PM

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_249-A_90_%280310%29&residence=AL Go Links

Let's get started by collecting information. We'll hide questions that are not applicable to you based on your input errors and hide questions that are not applicable to you based on your input errors.

Current coverage
Please select the option that best describes your situation.

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

Contact information

First name: John Last name: Doe

Home phone: 210-357-2222 Work phone: 210-357-2222 Alternate phone: 210-357-2222

E-mail address: jdoe@yahoo.com

Home address

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

City: Anytown State: AL Zip: 12365-4568

Business address

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

City: Anytown State: AL Zip: 12365-4568

Advice from your virtual agent...



If you already have an account with MBA, simply login using your e-mail address and password and I'll complete most of the fields on this form for you.

MBAVP-A VAg2 (0509) OK

Done Internet

start I... I... S... M... R... T... R... D... Desktop My Computer 2:15 PM

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_249-A_90_%280310%29&residence=AL Go Links

Let's get started by collecting information. Please select the option that best describes your situation. Each question in order to alert you to input errors and hide questions that are not applicable.

Current coverage
Please select the option that best describes your situation.

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

Contact information

First name: John

Home phone: [] Work phone: 210-357-2222 Alternate phone: 210-357-2222

This field is required.

E-mail address: jdoe@yahoo.com

Home address

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

City: Anytown State: AL Zip: 12365-4568

Business address

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

City: [] State: [] Zip: []

Oops!



There are several minor issues we need to address before we can continue.

I have marked the problem fields with red text indicating why the field is invalid and how to correct it.

Please make the required corrections and press the continue button again.

MBAVP-A VAgTE (0509) [OK]

Done Internet

start I... I... S... M... R... T... R... D... Desktop My Computer 2:26 PM

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_249-A_90_%280310%29&residence=Al Go Links

Check or Money Order. You will have the option to pay quarterly or semi-annually and will receive premium due notices four to six weeks prior to premium being due.

Checking account information

Each month, MBA will debit your personal checking account for the amount due for your premium payment. All you have to do is record the debit in your check register on the fifth of each month. The debit will appear on your monthly statement from your bank.

You may transfer your account to a different bank or another branch of the same bank at any time. Just give us a few weeks notice so we can send you a new EFT authorization and process the paperwork.

If there are insufficient funds in your account, your life insurance may lapse and your EFT privilege may be revoked.

This service is available only for United States residents.

To take advantage of EFT, you will need a checking account with a routing/transit number and a checking account number. If you do not have a checking account, you may open one with the First Credit Union, 1234 Main St., Anytown, VA 20153-1111. For more information, contact the First Credit Union, 1234 Main St., Anytown, VA 20153-1111. Association, 14605 Avion Parkway,

Important information



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

You will need to send a check or money order for your first three months premiums to obtain immediate coverage following approval when paying by electronic funds transfer.

OK

Name and address of financial institution
[First Credit Union, 1234 Main St., Anytown, VA 20153-1111](#)
(First Credit Union, 1234 Main St., Anytown, VA 20153-1111)

Routing/transit number (first 9 digits from front of check)

(if your checking account is through a credit union, please contact them for this number)

Checking account number

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

MBA_249-A_90_(0310)

Done Internet

start Inf... In... Se... MB... RE... Te... Do... Desktop My Computer 2:28 PM

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_249-A_90_%280310%29&residence=AL Go Links

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?

- 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 or semi-annually and will receive 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
8354-6879-8465-1321
(xxxx-xxxx-xxxx-xxxx)
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.

MBA_249-A_90_(0310)

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.

MBAVP-A VAgcCC(0509)

Done Internet

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MBA Term 90 Life Insurance Coverage FOR SPONSORED SPOUSE MEMBERS

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 (MBA).

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

Current Mailing Address _____
_____ Zip _____

Home Phone No. (_____) _____
Work Phone No. (_____) _____
Alternate Phone No. (_____) _____
E-mail Address: _____
Permanent Home Address (Address from which mail will always be forwarded to you).
_____ Zip _____

PLEASE PROVIDE SPONSOR INFORMATION

SPONSOR'S Name _____

SPONSOR'S SSN _____

SPONSOR'S Status:

- a. An insured member of MBA
b. Military

Rank _____ Branch of Service _____

Duty Status: (Check one)

- Full-Time Active Duty Retired
 National Guard Ready Reserve

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

- c. Full-time U.S. Government Civilian Employee.

SPONSOR'S unit or work assignment for purpose of verification:

Telephone No. (_____) _____

CHECK ONE:

- New Member Coverage Addition Coverage Change

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.

I am enclosing with this application: (Check one)

- A copy of the military allotment authorization form. (I want my life insurance 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 _____ Yr / _____ Mo)
- 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.)

FAMILY LIFE INSURANCE COVERAGE

If applying for this coverage, please list 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	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 _____

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_248-A_90_(0310)

(0310) 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_248-A_90_(0310)

(0310) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

MBA Term 90 Life Insurance

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION APPLICATION FORM
Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)

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 (MBA).

NAME _____ **SSN** _____
(Please Print) First Middle 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: _____
Alternate Phone: _____

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

Zip _____

Work Phone: _____
E-mail Address: _____

a. I am a U.S. Citizen: Yes No

b. I am a full-time civilian employee of the U.S. Government? Yes No

I am enclosing with this application: (Check one)

A copy of the military allotment authorization form. (I want my life insurance to begin the first day of the month coincident with or next following both (a) approval by GPM Life of my application 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 premium. **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 Coverage Addition Coverage Change

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) = \$ _____

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 249-A 90 (0310)

(0310) 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 249-A 90 (0310)

(0310) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

Statement of Variability

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

FORM NUMBER MBA_248-A_90_(0310)

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



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

4-21-2010

DATE

Statement of Variability

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

FORM NUMBER MBA_249-A_90_(0310)

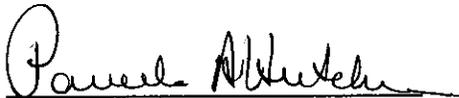
The coverage amounts shown in this form are bracketed and are intended to be variable.

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

4-21-2010

DATE

**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: Government Personnel Mutual Life Insurance Company

Form Titles: Life Insurance Application (for Sponsored Spouse Members)
Life Insurance Application (for U.S. Government Civilian Employees)

Form Numbers: MBA_248-A_90_(0310)
MBA_249-A_90_(0310)

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 & Chief Actuary

May 3, 2010
Date

May 3, 2010

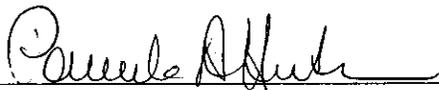
To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, 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

By: 

Title: Senior Vice President & Chief Actuary

MBA Term 90 Life Insurance

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION APPLICATION FORM
Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)

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 (MBA).

NAME _____ **SSN** _____
(Please Print) First Middle 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: **Home** _____
Alternate Phone: _____

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

Work Phone: _____
E-mail Address: _____

- a. I am a U.S. Citizen: Yes No
- b. I am a full-time civilian employee of the U.S. Government? Yes No

I am enclosing with this application: (Check one)

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

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) = \$ _____

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

FAMILY LIFE INSURANCE COVERAGE

For coverage, please list your spouse and all unmarried children 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

This paragraph was moved.

SERFF Tracking Number: FRCS-126612864 State: Arkansas
 Filing Company: Government Personnel Mutual Life Insurance State Tracking Number: 45592
 Company
 Company Tracking Number: 5364
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: MBA Electronic apps MBA_248-A_90_(0310) and MBA_249-A_90_(0310)
 Project Name/Number: GPM/69/69

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)
05/05/2010	Form	Life Insurance Application (for U.S. Government Civilian Employees)	06/24/2010	MBA_249-A_90_(0310) DIST.pdf (Superceded)
06/24/2010	Supporting Document	John Doe applications	06/24/2010	MBA_248-A_90_(0310) Spouse John Doe DIST.pdf app MBA_249-A_90_(0610) revised Cert JDoe Married.pdf (Superceded) app MBA_249-A_90_(0610) revised Cert JDoe Single.pdf (Superceded)
05/05/2010	Supporting Document	John Doe applications	06/24/2010	MBA_248-A_90_(0310) Spouse John Doe DIST.pdf MBA_249-A_90_(0310) Civilian John Doe married DIST.pdf (Superceded) MBA_249-A_90_(0310) Civilian John Doe single DIST.pdf (Superceded)

MBA Term 90 Life Insurance

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION APPLICATION FORM
Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)

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 (MBA).

NAME _____ **SSN** _____
(Please Print) First Middle 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: _____
Alternate Phone: _____
Permanent Home Address (Address from which mail will always be forwarded to you.)

_____ Zip _____
Work Phone: _____
E-mail Address: _____

a. I am a U.S. Citizen: Yes No
b. I am a full-time civilian employee of the U.S. Government? Yes No

CHECK ONE: New Member Coverage Addition Coverage Change

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) = \$ _____

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

I am enclosing with this application: (Check one)

A copy of the military allotment authorization form. (I want my life insurance to begin the first day of the month coincident with or next following both (a) approval by GPM Life of my application 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 premium. 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).

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_249-A_90_(0310)

(0310) 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_249-A_90_(0310)

(0310) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

MBA Term 90 Life Insurance

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION APPLICATION FORM
Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)

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 (MBA).

NAME John A Doe **SSN** 235-48-7988
(Please Print) First Middle Last

Actual Age 35 Date of Birth 04 / 02 / 1975
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

Home Address (Address from which mail will always be forwarded to you.)
1234 Main St.
Anytown, AL Zip 12365-4568

Home Phone: 210-357-2222
Alternate Phone: 210-357-2222
Business Address _____

1234 Main St.
Anytown, AL Zip 12365-4568

Work Phone: 210-357-2222
E-mail Address: jdoe@yahoo.com

a. I am a U.S. Citizen: Yes No

b. I am a full-time civilian employee of the U.S. Government? Yes No

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

I am enclosing with this application: (Check one)

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 premium. 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 Coverage Addition Coverage Change

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

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	04-10-1975	Wife

NAME John A Doe SSN 235-48-7988
 (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 6' 1" Weight 180 Spouse's Height 5' 7" Weight 150
 (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 235-48-7988
(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 Anytown, AL 04-21-2010
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_249-A_90_(0610)

(0610) 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_249-A_90_(0610)

(0610) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

MBA Term 90 Life Insurance

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION APPLICATION FORM
Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)

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 (MBA).

NAME John A Doe **SSN** 235-48-7988
(Please Print) First Middle Last

Actual Age 35 Date of Birth 04 / 02 / 1975
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

Home Address (Address from which mail will always be forwarded to you.)
1234 Main St.
Anytown, AL Zip 12365-4568

Home Phone: 210-357-2222
Alternate Phone: 210-357-2222
Business Address _____

1234 Main St.
Anytown, AL Zip 12365-4568

Work Phone: 210-357-2222
E-mail Address: jdoe@yahoo.com

a. I am a U.S. Citizen: Yes No
b. I am a full-time civilian employee of the U.S. Government? Yes No

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

I am enclosing with this application: (Check one)

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 premium. 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 Coverage Addition Coverage Change

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) = \$ _____

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 6' 1" Weight 180 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 235-48-7988
(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 Anytown, AL 04-21-2010
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_249-A_90_(0610) (0610) 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_249-A_90_(0610) (0610) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

MBA Term 90 Life Insurance

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION APPLICATION FORM
Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)

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 (MBA).

NAME John A Doe **SSN** 235-48-7988
(Please Print) First Middle Last

Actual Age 35 Date of Birth 04 / 02 / 1975
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 12365-4568
Home Phone: 210 - 357-2222
Alternate Phone: 210 - 357-2222
Permanent Home Address (Address from which mail will always be forwarded to you.)

1234 Main St.
Anytown, AL Zip 12365-4568
Work Phone: 210 - 357-2222
E-mail Address: jdoe@yahoo.com

a. I am a U.S. Citizen: Yes No
b. I am a full-time civilian employee of the U.S. Government? Yes No

CHECK ONE: New Member Coverage Addition Coverage Change

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

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	04-10-1975	Wife

I am enclosing with this application: (Check one)

A copy of the military allotment authorization form. (I want my life insurance to begin the first day of the month coincident with or next following both (a) approval by GPM Life of my application 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 premium. 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).

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 6' 1" Weight 180 Spouse's Height 5' 7" Weight 150
 (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 235-48-7988
(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 Anytown, AL 04-21-2010
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_249-A_90_(0310) (0310) 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_249-A_90_(0310) (0310) 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 Life) under policy number GP01.
Not available in all states.*

www.gpmlife.com



Printed on recycled paper

MBA Term 90 Life Insurance

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION APPLICATION FORM
Underwritten by Government Personnel Mutual Life Insurance Company (GPM Life)

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 (MBA).

NAME John A Doe **SSN** 235-48-7988
(Please Print) First Middle Last

Actual Age 35 Date of Birth 04 / 02 / 1975
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 12365-4568
Home Phone: 210 - 357-2222
Alternate Phone: 210 - 357-2222
Permanent Home Address (Address from which mail will always be forwarded to you.)
1234 Main St.
Anytown, AL Zip 12365-4568
Work Phone: 210 - 357-2222
E-mail Address: jdoe@yahoo.com

a. I am a U.S. Citizen: Yes No
b. I am a full-time civilian employee of the U.S. Government? Yes No

I am enclosing with this application: (Check one)

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

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) = \$

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

NAME John A Doe SSN 235-48-7988
 (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 6' 1" Weight 180 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 235-48-7988
(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 Anytown, AL 04-21-2010
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_249-A_90_(0310) (0310) 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_249-A_90_(0310) (0310) 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 Life) under policy number GP01.
Not available in all states.*

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