Generations Plus Application

AAFMAA® COMPASSION • TRUST • PROTECTION

Please read Application Instructions page and complete all sections.

For office use (Policy Number)

1. PERSONAL

Insured Name *(Last, First MI)*		Rank/Title	Social Security Number
Email (☐ *Personal* ☐ *Work)*		Gender ☐ Male ☐ Female	Birth Date *(mm/dd/yyyy)*
Street		Phone (☐ *Cell* ☐ *Home* ☐ *Work)*	
City	State / Zip	Phone (☐ *Cell* ☐ *Home* ☐ *Work)*	
Member Name		Member SSN	Member is applying for *(select one)* ☐ Child ☐ Grandchild

2. INSURANCE

Amount *(select one)*
☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Monthly Premium *(from table)*
$

3. PAYMENT. *(Applications cannot be processed without a deposit.)*

Payment Type	Required Deposit
☐ Military allotment monthly	2 months
☐ Checking account monthly *(EZ-Pay)**	1 month
***Attach blank check marked "VOID" - not deposit slip.**	
☐ Credit card monthly	1 month
☐ Bill quarterly	3 months
☐ Bill semiannually	6 months
☐ Bill annually	12 months

Account Holder/Payer Name

Account Holder Mailing Address

Bank Account Number OR Credit Card Number

Bank ABA Routing Number OR Credit Card Expiration Date

Policy Delivery Preference: ☐ Electronic ☐ Paper

4. BENEFICIARY. *(Equal shares to surviving primaries, else contingents, else estate.)*

PRIMARY: Name *(Last, First MI)*	Social Security Number	Birth Date *(mm/dd/yyyy)*	Relationship to Insured
PRIMARY: Name *(Last, First MI)*	Social Security Number	Birth Date *(mm/dd/yyyy)*	Relationship to Insured
CONTINGENT: Name *(Last, First MI)*	Social Security Number	Birth Date *(mm/dd/yyyy)*	Relationship to Insured
CONTINGENT: Name *(Last, First MI)*	Social Security Number	Birth Date *(mm/dd/yyyy)*	Relationship to Insured

5. MEDICAL INFORMATION. *(Provide explanations for all "YES" answers in the space provided.)*

1. Within the past five years, have any of the children listed above been treated or diagnosed by a physician for: respiratory disorder, heart disease or disorder, mental disease or disorder, or any other impairments or diseases? ☐ Yes ☐ No
2. Was any child born prematurely or with abnormalities at birth? *(Skip if child is more than 1 year old)* ☐ Yes ☐ No

Provide explanations for "YES" answers here.

Do not write in this space. Application processing by AAFMAA			Comments
Date Received	Deposit Received	Recommendation ☐ Accept ☐ Withdraw ☐ Defer	
Date Accepted	Identification Received	Signature of AAFMAA Reviewing Authority	

American Armed Forces Mutual Aid Association • 1856 Old Reston Ave, Ste 200, Reston, VA 20190 • 1-800-522-5221 • www.aafmaa.com

6. AUTHORIZATION

I hereby apply to AAFMAA for insurance as provided by its Constitution. I represent that my statements and answers are true to the best of my knowledge. I understand that AAFMAA will rely on my statements and answers in determining my eligibility for insurance and receiving my application. I also understand that any false or incomplete statement or answer which materially affects the acceptance or the risk or the hazard assumed may result in loss of coverage under the policy to which this application is attached. I understand that any photocopy amendment or statement I submit may be accepted and relied upon by AAFMAA, in its sole and absolute discretion, and treated as a valid original, and will be included in any approved policy that is issued and delivered to the owner. I understand that federal law requires AAFMAA to verify the identity of insureds and owners. I understand that all documents I provide will be retained by AAFMAA.

I understand that the insurance coverage applied for will be effective conditionally from the date AAFMAA receives my application, deposit, identification and required medical information, whichever is later. If I die before this application is approved and a policy issued, and it is determined by AAFMAA, pursuant to its rules and procedures, that I am not acceptable to AAFMAA for the insurance coverage applied for as of the date of the application, there shall be no insurance coverage, no death benefit will be payable, and any deposit paid will be refunded. Based on my health and other factors affecting my insurability, I may be offered a higher premium rate or my application may be rejected or withdrawn.

I authorize any health care providers, pharmacy benefit manager or other pharmaceutical firm, insurance companies, MIB, Inc., consumer reporting agency, the Department of Motor Vehicles, financial institution, or employer having information about my physical or mental condition, prescription drug records, financial status, employment status or other relevant information about me, to give all information to AAFMAA to determine eligibility for insurance or benefits. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. I authorize AAFMAA to make a brief report of my personal health information to MIB. Information obtained may be released to persons performing business duties as delegated or contracted for by AAFMAA related to my application and subsequent insurance related functions, as permitted or required by law, or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I agree this authorization is valid for 24 months, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. For purposes of collecting information in connection with a claim for benefits, this Authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by written request to AAFMAA; (2) revocation of this authorization will not affect any prior action taken by AAFMAA in reliance upon this authorization; and (3) failure to sign or revocation of this authorization may impair AAFMAA's ability to evaluate applications or claims and may be the basis for denying this application or claim for benefits.

If I have chosen to pay by recurring withdrawal from my military allotment, bank account or credit card, I hereby authorize AAFMAA to contact DFAS or the payment provider on my behalf to start, increase, decrease or stop my payment when necessary to collect amounts currently due. I understand that AAFMAA cannot start or increase active duty allotments.

☐ I AGREE for AAFMAA to obtain information from Experian solely to verify my identity and military service from my personal credit report or other sources, and provide this written consent as required by the Fair Credit Reporting Act. *(Required - you must check this box.)*

☐ I AGREE for AAFMAA to use my phone numbers to verify my identity by providing to a third-party to send a One-Time Password via SMS text message. Mobile messaging rates may apply. *(Optional - check box if desired.)*

Privacy Policy information is available at www.aafmaa.com/AboutAAFMAA/PrivacyPolicy.aspx or by mail by calling 1-877-298-2263.

7. PARENT. *(Required)*

Parent Name *(Last, First MI)*			Birth Date *(mm/dd/yyyy)*	Social Security Number
Street			Gender ☐ Male ☐ Female	Phone (☐ *Cell* ☐ *Home* ☐ *Work)*
City	State	Zip	E-mail (☐ *Personal* ☐ *Work)*	
Parent Signature		Parent Printed Name *(First MI Last)*		Date *(mm/dd/yyyy)*

8. OWNER. *(Required if other than parent)*

Owner Name *(Last, First MI)*			Relation to Insured	Social Security Number
Street			Gender ☐ Male ☐ Female	Phone (☐ *Cell* ☐ *Home* ☐ *Work)*
City	State	Zip	E-mail (☐ *Personal* ☐ *Work)*	
Owner Signature		Owner Printed Name *(First MI Last)*		Date *(mm/dd/yyyy)*

AAFMAA Generations Plus Life Insurance

Are you an AAFMAA member? Do you have children or grandchildren age 14 and under? If so, buy AAFMAA's Generations Plus for them. It is great because:

- Premiums are lower than Gerber Grow-up Plan
- Premiums never change -- the younger the child, the lower the premium
- Coverage automatically doubles at age 18 -- no premium increase
- Policy ownership automatically changes to insured at age 21
- Guaranteed 4 additional insurance purchase options, regardless of medical condition
- Exercising all options provides insurance equal to 10 times the initial policy

Here's how it works

Buy an Initial Policy of	$10,000	$15,000	$20,000	$25,000	$30,000	$40,000	$50,000
At Age 18 (coverage doubles with no premium increase)	$20,000	$30,000	$40,000	$50,000	$60,000	$80,000	$100,000
At Age 35 or 40 (if all 4 guaranteed purchase options are exercised)	$100,000	$150,000	$200,000	$250,000	$300,000	$400,000	$500,000

Monthly Premiums

Issue Age	$10,000	$15,000	$20,000	$25,000	$30,000	$40,000	$50,000
Under 1*	$7.10	$10.65	$14.20	$17.75	$21.30	$28.40	$35.50
1	$7.30	$10.95	$14.60	$18.25	$21.90	$29.20	$36.50
2	$7.50	$11.25	$15.00	$18.75	$22.50	$30.00	$37.50
3	$7.70	$11.55	$15.40	$19.25	$23.10	$30.80	$38.50
4	$8.00	$12.00	$16.00	$20.00	$24.00	$32.00	$40.00
5	$8.20	$12.30	$16.40	$20.50	$24.60	$32.80	$41.00
6	$8.50	$12.75	$17.00	$21.25	$25.50	$34.00	$42.50
7	$8.70	$13.05	$17.40	$21.75	$26.10	$34.80	$43.50
8	$9.00	$13.50	$18.00	$22.50	$27.00	$36.00	$45.00
9	$9.20	$13.80	$18.40	$23.00	$27.60	$36.80	$46.00
10	$9.50	$14.25	$19.00	$23.75	$28.50	$38.00	$47.50
11	$9.80	$14.70	$19.60	$24.50	$29.40	$39.20	$49.00
12	$10.10	$15.15	$20.20	$25.25	$30.30	$40.40	$50.50
13	$10.40	$15.60	$20.80	$26.00	$31.20	$41.60	$52.00
14	$10.80	$16.20	$21.60	$27.00	$32.40	$43.20	$54.00

*minimum age of 15 days

Call AAFMAA toll free at 1-877-398-2263 for more information.

When completed:

- Scan application to membership@aafmaa.com
- Fax to 1-888-210-8201

Supplementary Information

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MIB Disclosure

This information is required by MIB, which assists AAFMAA in considering your application.

Information regarding your insurability will be treated as confidential. AAFMAA may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or submit a claim for benefits to such a company, MIB, upon request, will supply each company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 886-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information offices is 500 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

AAFMAA may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.