Application for Membership and Insurance with the
UNITED STATES LETTER CARRIERS MUTUAL BENEFIT ASSOCIATION

Home Office: 100 Indiana Avenue N.W., Washington, DC 20001, Phone (202) 638-4318
Executive Office: Nashville, TN nalc.org/mba

A Fraternal Benefit Society

Individual Disability Income

DI/SD

1. Benefit Period Desired (check one): ❑ **6 Month** ❑ **12 Month**

2. Benefit Amount Desired: (check one): ❑ **$650 / Month** ❑ **$1,350 / Month** ❑ **$2,000 / Month**

3. NALC Member's Name: _____ NALC Branch No. _____

   Social Security Number: _____ Sex _____ (M or F) Date of Birth _____ (Mo. / Day / Yr.)

4. Home Address: _____
   Street City State Zip Code

   Telephone No.: (_____)_____
   Area Code

5. **Payroll Deduction:** I hereby authorize the U.S. Postal Service: (1) to deduct each pay period from my salary or wages such amounts as may be required by the United States Letter Carriers Mutual Benefit Association ("USLCMBA") to pay premiums due from me for insurance; and (2) to pay the amounts thereof on my behalf to the USLCMBA. The authorization shall continue during my employment in any capacity by the U.S. Postal Service until canceled by me by written notice to the USLCMBA.

   Note: By signing below, you authorize deduction of your premium unless you check a box below. Payroll deductions start approximately twenty-eight (28) days after receipt of your application.

   I do not want to use payroll deduction (check one): ❑ Bill monthly ❑ Bill annually

   Additional Premium Enclosed: _____

6. **Existing Coverage:** Are you currently covered by an existing disability income insurance policy? ❑ NO ❑ YES

   If "YES", please indicate: Name of Insurance Company: _____ Policy No.: _____

   Is the disability income insurance applied for by this application intended to replace or change any disability income insurance in force, either with the USLCMBA or any other company? ❑ NO ❑ YES

   If "YES", then if the policy being replaced is different than that listed above, provide information on that policy:

   Name of Insurance Company: _____ Policy No.: _____

APPLICATION CONTINUES ON REVERSE SIDE

7. **Medical Information:** Within the last ten (10) years, by a member of the medical profession, have you been diagnosed, treated, hospitalized or recommended for treatment, including prescription drug use, for any of the following:

1. High blood pressure, coronary artery disease, heart attack, stroke, other heart disease or disorder of the circulatory system?	❑ NO	❑ YES
2. Emphysema, chronic respiratory disease or other disorder of the respiratory system?	❑ NO	❑ YES
3. Any disease or disorder of the brain or nervous system?	❑ NO	❑ YES
4. Hepatitis or other disease or disorder of the liver?	❑ NO	❑ YES
5. Any disease or disorder of the stomach, intestines, pancreas, rectum, colon, or abdominal organs?	❑ NO	❑ YES
6. Any disease or disorder of the eyes, ears, nose or throat?	❑ NO	❑ YES
7. Any disease or disorder of the blood, skin, thyroid, lymph or other glands?	❑ NO	❑ YES
8. Cancer, tumor, cyst or nodule?	❑ NO	❑ YES
9. Any disease or disorder of the genito-urinary glands?	❑ NO	❑ YES
10. Diabetes that requires insulin?	❑ NO	❑ YES
11. Any disease or disorder of the skeletal system?	❑ NO	❑ YES
12. Any arthritis, injury or disorder of the spine, neck or back, jaw, arm, leg, shoulder, wrist, hand, hip, knee, ankle, or foot?	❑ NO	❑ YES
13. Any psychiatric or mental health disorder or disease?	❑ NO	❑ YES
14. Any gynecological disorders or diseases?	❑ NO	❑ YES
15. Any sexually transmitted disorders or diseases?	❑ NO	❑ YES
16. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder?	❑ NO	❑ YES
17. Any disorders or diseases of the immune system (except those related to the Human Immunodeficiency Virus (AIDS virus))?	❑ NO	❑ YES

This information will not be used for policy issue purposes, but may be used for the pre-existing condition limitation of the policy.

8. **Effective Date:** Insurance applied for by this policy application will become effective on the date the USLCMBA receives the first premium payment, provided the USLCMBA approves this application and issues a policy of insurance.

   I understand and agree that this application, as completed and signed, will form the basis of the policy issued.

   I understand and agree that for any person covered by the policy applied for by this application, USLCMBA will not pay any benefit, or any increase in benefits, under the policy for any disability that results from, or is caused or contributed to by, a pre-existing condition during the 12 months after the effective date of coverage. I authorize physicians and medical institutions for furnish the USLCMBA with information regarding medical history, physical condition and diagnosis of the insured.

   I have considered my present health insurance coverage and income, and feel that the policy applied for by this application is the amount and kind of insurance I need to supplement my present health insurance coverage and is suitable for me.

9. **Fraud Notice:** Any Person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

   By signing below, I hereby certify and confirm that I am an active member of the National Association of Letter Carriers (NALC) and current employee of the U.S. Postal Service, and that I will be the Insured, Owner, and Payor of the Individual Disability Income policy associated with this application.

Signature of Member _____ Date _____