❑ This application is to increase coverage from Plan _____ to Plan _____ on Policy Certificate # _____.

❑ This application is to add the Dependent(s) listed below to Policy #_____. (Member: Answer the medical questions for the Dependents listed only.)

AIR FORCE ASSOCIATION
AFA VETERAN BENEFITS ASSOCIATION

AFAVBA Use Only
Date/Amt Rcvd_____
Record # _____
Dues paid _____
Met ❑ Appr ❑ Decl _____
Cert #_____
Eff Date _____
Fam/Ind _____
Cvg _____
Prem _____

APPLICATION FOR

AFA VETERAN BENEFITS ASSOCIATION GROUP DECREASING TERM LIFE INSURANCE

Name _____ Rank _____

Street Address _____

City _____ State _____ Zip _____

Daytime Phone _____ E-mail Address _____

Social Security#_____ Date of Birth (mo/day/yr) _____ Age _____

Height _____ Weight_____ ❑ Male ❑ Female

In the last year, have you used any tobacco products? ❑ Yes ❑ No

Check (✓) your eligibility:

❑ I have served in the U.S. Military.

❑ I am the spouse/widow of someone who served in the U.S. Military.

❑ I am the ancestor (parent/grandparent, etc.) or lineal descendent (child/grandchild, etc.) of someone who served in the U.S. Military.

I meet the following membership criteria for this plan:

❑ I am a member of AFA and/or AFAVBA

❑ I am not a member, so I am adding:

- ❑ $1 for AFAVBA Annual Membership Dues **OR**
- ❑ $45 for AFA Annual Membership Dues (supports the mission of AFA to promote Air Power, and includes *AIR FORCE Magazine* monthly, and many more membership benefits)

Beneficiary Designation:

For Family coverage, the Member receives the insurance proceeds when an insured Family Member dies. List your beneficiary (ies) in the event of the Member's death. Please provide Name, Relationship and Social Security #. If naming more than one beneficiary, provide percentage. **Primary beneficiaries** are the individuals that you wish to receive the insurance proceeds in the event of your death. You may have them divided among several primary beneficiaries. To do this, indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%. **Contingent beneficiaries** receive the proceeds if all primary beneficiaries predecease the insured. If more room is needed, attach a signed, dated letter stating your preferences. Note: Listing someone as a beneficiary is NOT adding coverage for them. For Family coverage, list dependent information in the Family Coverage section below.

Beneficiary(ies)	Name	Relationship	Social Security #	%
Primary(ies)				
Contingent				

Plan of Coverage: Check One:

	❑ Standard		❑ High Option		❑ High Option Plus		❑ Select	
	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage
Pay Monthly*	$10.00	$12.50	$15.00	$17.50	$20.00	$22.50	$30.00	$32.50
Pay Quarterly	$30.00	$37.50	$45.00	$52.50	$60.00	$67.50	$90.00	$97.50
Pay Semiannually	$60.00	$75.00	$90.00	$105.00	$120.00	$135.00	$180.00	$195.00
Pay Annually	$120.00	$150.00	$180.00	$210.00	$240.00	$270.00	$360.00	$390.00

**only if paying by auto debit, auto charge or government allotment*

If you are requesting Family Coverage, please complete the following for each person to be insured:

	Dependent	Relationship	Date of Birth	Height	Weight
1.					
2.					
3.					
4.					

Attach list if more room is needed.

Payment Instructions:

A minimum of a quarterly premium must be included with this application either by check or credit card. Future payments can be made by check, credit card, automatic deduction from a checking account, or by government allotment. Please indicate your preferred method of payment on next page.

Initial Payment:

Check enclosed for: ❑ Quarterly Premium ❑ Semiannual Premium ❑ Annual Premium

Charge my credit card below for: ❑ Quarterly Premium ❑ Semiannual Premium ❑ Annual Premium

Future Payments:

❑ Bill me directly: ❑ Quarterly ❑ Semiannually ❑ Annually

❑ I will arrange for government allotment; send me details.

❑ I have attached a voided check and give AFAVBA permission to debit my checking account:
❑ Monthly ❑ Quarterly ❑ Semiannually ❑ Annually

❑ Charge my credit card below: ❑ Monthly ❑ Quarterly ❑ Semiannually ❑ Annually
Credit Card Info: ❑ VISA ❑ MasterCard
Credit Card # ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ Exp. Date ☐☐/☐☐
Signature _____

Answer the following questions for you and any dependents for whom you are requesting coverage:

	Yes	No
1. Has any person for whom coverage is being requested been hospitalized during the preceding 90 days? "Hospitalized" means inpatient confinement for: hospital care, hospice care or care in an intermediate or long-term care facility. It also includes outpatient hospital care for chemotherapy, radiation therapy, or dialysis treatment.	❑	❑
2. Have you ever received treatment for or been told you had:		
a. Cancer, tumors, leukemia, Hodgkins disease, or other associated malignancies?	❑	❑
b. Heart disease, high blood pressure, stroke, or other cardiovascular disease?	❑	❑
c. AIDS or AIDS related complex (ARC)?	❑	❑
3. Within the past 3 years have you had chest discomfort, tuberculosis, lung disease, ulcers, diabetes, mental or nervous disorder, neck or spinal disorder?.	❑	❑
4. In the past 5 years has any physician or other medical practitioner advised or treated you for any disease, ailment, or injury not revealed elsewhere in this application?.	❑	❑
5. Has any application for life or health insurance been declined, postponed or issued other than as applied for?	❑	❑
6. Is the proposed insured receiving (or have a pending request to receive) Workmen's Compensation or any other disability benefit?.	❑	❑

If you answered "Yes" to any of the above questions, attach a sheet of paper showing the name of the person to whom your answer applies and provide details, dates, diagnosis, treatment and name and address of the health care provider(s) and hospital(s).

I certify that the information in this application, a copy of which shall be attached to and made a part of my Certificate when issued, is given to obtain the plan requested and is true and complete to the best of my knowledge and belief. I agree that no insurance will be effective until a Certificate has been issued and the initial premium paid. I understand that the coverage will not become effective until approved by MetLife. I understand that if on the Effective Date: (1) I am not eligible for such insurance by reason of (i) age or (ii) membership/veteran requirement status, insurance will not become effective on my life; (2) any person to be insured (including spouse or children) is hospitalized, insurance will not become effective on the life of that person until approved by MetLife; and (3) my spouse is receiving, is entitled to receive or would be entitled to receive upon timely application, any benefit due to sickness or injury (other than medical expense benefits) under any private policy or plan or government program whether insured or noninsured, insurance will not become effective on the life of my spouse until approved by MetLife.

Authorization to Furnish Medical Information: For underwriting and claim purposes, I hereby authorize any physician or other medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization to furnish MetLife, on my behalf, with information in his or its possession, including the findings relating to medical, psychiatric or psychological care or examination, or surgical treatment given to the undersigned. This authorization shall be valid for 2 years. A photocopy of this authorization shall be considered as effective and valid as the original.

Member's Signature_____ Date _____

If applying for Family Coverage: Spouse's Signature _____ Date _____

Dependent Child's Signature (if over 18) _____ Date _____

Metropolitan Life Insurance Company Home Office: NY

Mail your completed application and initial payment to: **AFAVBA, 1501 Lee Highway, Arlington, VA 22209-1198**

MetLife's Consumer Privacy Notice

We will evaluate your request for coverage to see whether you are eligible for this coverage. We will first review all of the information furnished by you on your application form. We may confirm or add to this information in the ways described in this notice. All applicants are treated in a fair way.

We will tell you if we cannot give you the coverage you requested. We will always tell you in general terms the reason for our decision. Unless prohibited by applicable laws, we will usually provide you with specific details regarding our decision. Otherwise, we will disclose the information through the licensed physician you choose.

INFORMATION COLLECTION The enrollment and statement of health on your application form is our main source of information. To evaluate your request properly, we may obtain additional data from third parties about any person proposed for coverage. For example, we may:

- Ask you to have a medical evaluation, which may include tests such as an electrocardiogram
- Ask physicians, hospitals, or other medical care providers to confirm or add to the medical data you have given us
- Obtain a report from a consumer reporting agency. Information about this report and the rights you have under Federal law and your state's law, if any, is provided below. In addition, we may request information from you or from third parties from which we will be able to draw conclusions about your personal characteristics such as your habits or your health.

INFORMATION MAINTENANCE AND USE We treat the information we have about you in a confidential way. We will use it for business purposes relating to the coverage provided under your organization's benefit plan or plans. For example, it may be used when we evaluate any claims you submit for benefits under this plan.

INFORMATION DISCLOSURE In most cases, the information we have about you will be sent to third parties only if you authorize us to do so. For example, under the authorization which you have completed on the application form, the information may be sent to our reinsurers and others who perform business services for us.

In some cases where disclosure is required by law and/or is necessary for the conduct of our business, we may send the information to third parties without your consent. For example, it may be given to other insurers or insurance support organizations when we believe it may help us detect or prevent fraud or misrepresentation. It may be disclosed to a medical professional for the purpose of verifying insurance coverage or benefits, informing you of medical problems which you may not know about, or for audits used to verify information provided to us by the medical professional. The information may also be disclosed to an insurance regulatory authority or to a law enforcement or other governmental authority when we believe it is necessary to protect our interests, or to prevent or prosecute fraud against us, or if we believe that illegal activities have been conducted by you. This information may also be used for the purpose of conducting actuarial or research studies or to our affiliate in connection with an audit of our company or the marketing of an insurance product or service. This information can also be provided to your organization for the purposes of reporting claims experience or if your organization requests an audit of our company.

ACCESS AND CORRECTION OF INFORMATION Upon your written request, we will make the information we have about you available to you. Medical information will be provided to you or disclosed through the licensed physician you choose or as otherwise required by law.

We will also permit you to see and copy such information pertaining to you or to obtain a copy of such information by mail, whichever you prefer. We will also disclose to you the identity of any third party to which we have disclosed this information within the past two years. If our files do not reflect the identity of third parties to whom we have disclosed this information, we will inform you of the identity of third parties to whom we normally disclose such information.

If you feel that the information in our files is wrong or incomplete, you may let us know and if we agree with you, we will correct, amend, or delete the portion of the information which you dispute. If we do not agree with you, we will notify you of our refusal to make this correction, amendment or deletion, the reasons for our refusal and your right to file a statement of dispute with us.

If we correct, amend, or delete the information as you request, we will notify you and we will furnish the correction, amendment, or deletion to any person who you specifically designate who may have received the information within the preceding two years, or any organization that furnished the corrected, amended, or deleted information to us, or to any third party whose primary source of information is insurance companies if the third party has received information from us within the preceding seven years.

If you choose to file a statement of dispute with us, you may provide us with a statement setting forth the information which you think is correct, relevant or fair, or a statement of the reasons why you disagree with our refusal to correct, amend, or delete the disputed information. We will file your statement with the disputed information and provide a means by which anyone viewing the disputed information will be made aware of your statement and have access to it. In addition, in any subsequent disclosure by us of the disputed information, we will clearly identify the matter or matters in dispute and provide your statement along with the information being disclosed. Finally, we will furnish your statement to any third party to whom we would provide a correction, amendment, or deletion of information as referenced above.

CONSUMER REPORTS MetLife may ask an independent source to confirm and add to the information which you have provided in your application. This report is known as a consumer report. Upon your request, we will inform you whether or not we requested a consumer report in connection with your application and if such a report was requested, we will provide you with the name and address of the consumer reporting agency that furnished the report to us. The information obtained from a consumer report may be retained by the consumer reporting agency and disclosed to other parties.