MOAA ACTIVE SERVICE DISCHARGE GROUP TERM LIFE INSURANCE ENROLLMENT FORM

The proposed insureds should complete the entire form. Please print clearly in dark ink. Eligibility for coverage is determined based on your answers below. Please note that you may not be eligible for this Plan.

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Military Officers Association of America | Policy No. 68652-2

1 MEMBER INFORMATION:

Name (Last, First, M.I.)	MOAA Member #		☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Social Security Number		
Address	City	State	Zip
Home/Cell Phone #	Email Address		

Are you enrolling within 90 days after your discharge from active service for any reason other than health or disability? ☐ **Yes** ☐ **No**

Member Life Insurance ☐ **$200,000** (Under Age 50) (D0Z1) ☐ **$100,000** (Under Age 70) (D0Y1) ☐ **$50,000** (Ages 50-74) (D0N1)

2 SPOUSE OF MEMBER INFORMATION: *(complete this section only if electing spouse coverage)*

The use of "spouse" in this form means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the plan.

Spouse Name (Last, First, M.I.)	Date of Birth (MM/DD/YYYY)	Social Security Number	☐ Male ☐ Female

Spouse of Member Life Insurance ☐ **$100,000** (Under Age 50) (D0Y5) ☐ **$50,000** (Under Age 75) (D0N5) ☐ **$25,000** (Ages 50-74) (D0H5)
Member must be covered in order for the spouse to obtain coverage. Spouse amount is limited to 50% of member amount or maximum allowed by age, whichever is less.

3 BENEFICIARY INFORMATION:

Include Name, Address, Date of Birth and Social Security Number for each beneficiary you list below.
List the percent each will receive. The total must equal 100 percent. Attach additional sheets if necessary.

Beneficiary for Member Coverage

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Beneficiary for Spouse of Member Coverage

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

4 READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW:

- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company, and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life Insurance Company.

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 the state law.

I hereby certify that I am a current member of MOAA or plan to enroll/accept membership in MOAA and I acknowledge that I will receive e-communications from MOAA.

Member's Signature X _____ **Date** X _____
(always required)

Spouse's Signature X _____ **Date** X _____
(if enrolling)

Don't send money now!

Mail your completed Enrollment Form to:
MOAA Insurance Plans • P.O. Box 14464 • Des Moines, IA 50306 • **Questions?** Call Toll-Free **1-800-247-2192**
(Hearing-impaired or voice-impaired members may call the Relay Line at 711-800-247-2192.)
Or, email moaa.service@mercer.com