

APPLICATION FOR THE MOAA LEADER TERM LIFE INSURANCE PLAN

Complete all information in ink.

1 Please give us the following information:

Member Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Date of Birth: ____ / ____ / ____ Male Female
mo day yr

MOAA Member Number: _____

Daytime Phone: (____) _____



Endorsed by:



Height (ft/in): _____

Weight (lbs): _____

2 Check who you want the MOAA Leader to protect:

Member Only	Member's Spouse Only	Member And Spouse	Member's Family*
<input type="checkbox"/> \$100,000.00 (_{_0Y1})	<input type="checkbox"/> \$100,000.00 (_{_0Y5})	<input type="checkbox"/> \$100,000.00 (_{_0Y1, _0Y5})	<input type="checkbox"/> \$100,000.00 (_{_0Y1 and/or _0Y5 and 00E7})
<input type="checkbox"/> \$50,000.00 (_{_0N1})	<input type="checkbox"/> \$50,000.00 (_{_0N5})	<input type="checkbox"/> \$50,000.00 (_{_0N1, _0N5})	<input type="checkbox"/> \$50,000.00 (_{_0N1 and/or _0N5 and 00E7})
<input type="checkbox"/> \$25,000.00 (_{_0H1})	<input type="checkbox"/> \$25,000.00 (_{_0H5})	<input type="checkbox"/> \$25,000.00 (_{_0H1, _0H5})	<input type="checkbox"/> \$25,000.00 (_{_0H1 and/or _0H5 and 00E7})
<input type="checkbox"/> \$ _____ other	<input type="checkbox"/> \$ _____ other	<input type="checkbox"/> \$ _____ other	<input type="checkbox"/> \$ _____ other

*Children 15 days to 6 months are eligible for \$1,000.00 of coverage and children ages 6 months to 21 years (25 if a full-time student) are eligible for \$10,000.00 of coverage.

Your beneficiary will be your spouse if living. Otherwise your beneficiary will be your children, parents, brothers or sisters, or estate in that order. The MOAA member is the beneficiary for spouse and children coverage. If you'd like to designate a different beneficiary, please complete below:

Beneficiary Relationship to MOAA Member

3 Please give us the following information if you want protection for your spouse or children:

Spouse Name: _____ Date of Birth: ____ / ____ / ____
mo day yr

Height (ft/in): _____ Weight (lbs): _____ Gender (M/F): _____

Child Name: _____ Gender (M/F): _____ Date of Birth: ____ / ____ / ____
mo day yr

Child Name: _____ Gender (M/F): _____ Date of Birth: ____ / ____ / ____
mo day yr

4 Please answer the following questions:

(Note: A "yes" answer does not automatically disqualify you from coverage.)

1. In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for:	Member		Spouse	
	YES	NO	YES	NO
A. A heart murmur, high blood pressure, stroke or any disease or disorder of the heart, blood or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Colitis, ulcer, kidney disease or any disease or disorder of the digestive, urinary or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones or joints, including neck or back disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any other immune deficiency disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Continued

	Member		Spouse	
	YES	NO	YES	NO
2. During the past 5 years has anyone proposed for coverage consulted any physician, surgeon, psychologist, psychiatrist, or other practitioner for any reason not previously noted on this application; or have they been confined or treated in any hospital, sanitarium or similar institution?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At any time during the last 12 months, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine product or snuff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 2 years, have you or your spouse been unable to perform the full-time duties of your occupation for 10 consecutive days, or if not employed, been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90-day period immediately preceding the date of this application for 10 consecutive days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you enrolling within 60 days after your discharge from active duty service for any reason other than health or disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If accepted for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "yes" to questions 1-2 or 4, please give full details.
 (If more space is needed, use a separate sheet and be sure to sign and date it.)

Question #/Letter	Person	Dates	Details of nature of illness, number of attacks, duration, severity, names and addresses of physicians and hospitals, date of full recovery.

5

Please provide the name, address and phone number of your current doctor:

Member's Doctor's Name: _____ Phone Number: (____) _____
 Address _____
 Spouse's Doctor's Name: _____ Phone Number: (____) _____
 Address _____

6

Please read, sign and date:

I hereby certify that I am a Member of MOAA and that I have read all statements and answers in this application and that they are full, complete and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentations materially affect the acceptance of the risk. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs. Subject to the deferred effective date provision, I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance just because I submit an application and pay my first premium. I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; consumer reporting agency; Medical Information Bureau, Inc.; or employer to give Hartford Life Insurance Company or its legal representative information about my or my dependents' physical or mental health, including history, condition, diagnosis and treatment, drug or alcohol use history, other insurance coverage, or employment status. Hartford Life Insurance Company will use the above information to decide if and to what extent I or my dependents are eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to the Hartford Life Insurance Company. I authorize the Hartford Life Insurance Company to give information about me or my dependents to: any other insurance company to whom I or my dependents may apply for Life or Health Insurance, the Medical Information Bureau, Inc., or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required by law. I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two years from the effective date of my coverage or my dependents' coverage, or if no coverage has been issued, one year from the date of this application. I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request. I certify that I have received the Notice of Insurance Information Practices.

Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. 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. In certain states, 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, the person is guilty of a felony in the third degree. Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false, misleading or deceptive information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.

Member's Signature **X** _____ Date **X** _____
 Spouse's Signature **X** _____ Date **X** _____
 (if applying)

Don't send money now! You'll be billed later.

Mail your completed Application 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 1-800-855-2881.)
 Or, e-mail moaa@marshpm.com