MOAA INSURANCE PLANS

# MOAA GROUP YOUTH TERM LIFE APPLICATION

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Please print clearly in dark ink.

Military Officers Association of America | Policy No. 68657-3

## 1 TELL US ABOUT YOURSELF:

**Member's Information:**

| Name (Last, First, M.I.) | MOAA Member # | Rank/Service | Social Security Number |
|---|---|---|---|
| Address | City | State | ZIP |
| Home/Cell Phone # | Work Phone # | Email Address | |

**Youth's Information** *(please complete a separate application for each Youth.)*

| Name (Last, First, M.I.) | Date of Birth (MM/DD/YYYY) | Height:_____ft. _____in. Weight:_____lbs. | ☐ Male ☐ Female |
|---|---|---|---|
| Social Security Number | Relationship to Member | Legal Parent/Guardian, if different than member | |
| Address | City / State | ZIP | Home/Cell Phone # |

## 2 SELECT THE AMOUNT OF COVERAGE:

The MOAA member will be the beneficiary for any Youth coverage issued unless the Member designates a different beneficiary pursuant to the terms of the Group Policy by contacting the Plan Administrator.

☐ $2,000 (A007) ☐ $5,000 (B007) ☐ $10,000 (C007)

Will the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? ☐ Yes ☐ No

If yes, please explain:_____

## 3 PROVIDE THE FOLLOWING HEALTH INFORMATION:

1) Has the Youth ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)? ☐ Yes ☐ No
2) Has the Youth ever had or been treated by a member of the medical profession or health practitioner for cancer; diabetes; arthritis; drug or chemical use or abuse; heart condition; liver, kidney or intestinal disease; mental or nervous disorder; or brain, neurologic or developmental disorder? ☐ Yes ☐ No
3) Has the Youth been hospitalized in the last 6 months? ☐ Yes ☐ No

**For every "Yes" to questions in the previous section, give details below. Please attach a separate sheet if additional space is needed.**

| Question # | Description of Condition | Date Condition Began | Description of Treatment Received | Health Practitioner Name, Full Address and Phone |
|---|---|---|---|---|
| | | | | |
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## 4 *READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW:*

**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.**

- To the best of my knowledge and belief, the information I have provided is complete and 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 made while the Insured is living and by the Insured's effective date.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life Insurance Company.

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)

**Youth's Signature** X _____ **Date** X _____
(If age 18 or older) or Legal Parent/Gaurdian (if different than Member for minor Youth)

## Don't send money now!

Mail your completed Application to:
MOAA Insurance Plans • P.O. Box 14536 • Des Moines, IA 50306 • **Questions?** Call Toll-Free **1-800-247-2192**
Or, email moaa.service@getamba.com