

AFA VETERAN BENEFITS ASSOCIATION MULTI-BENEFIT ACCIDENT INSURANCE

Name _____ Rank _____

Street Address _____

City _____ State _____ Zip _____

Daytime Phone _____

E-mail Address _____

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

Age _____ Male Female

PRE-APPROVED ACCEPTANCE GUARANTEED

You are PRE-APPROVED if you can check (✓) one:

- 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:

(please provide Name, Relationship, Social Security # and Percentage if naming more than one Primary Beneficiary)

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

Coverage Amounts:

	Common Carrier	Auto/Ped	Other
Plan 1			
Member & Spouse	\$100,000	\$50,000	\$15,000
Children	\$20,000	\$10,000	\$3,000
Plan 2			
Member & Spouse	\$150,000	\$75,000	\$25,000
Children	\$30,000	\$15,000	\$5,000
Plan 3			
Member & Spouse	\$250,000	\$125,000	\$40,000
Children	\$50,000	\$25,000	\$8,000

Plan of Coverage:

Check One:

	<input type="checkbox"/> Plan 3		<input type="checkbox"/> Plan 2		<input type="checkbox"/> Plan 1	
	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage	Individual Coverage	Family Coverage
Pay Quarterly	\$26.25	\$52.50	\$15.75	\$31.50	\$10.50	\$21.00
Pay Semiannually	\$52.50	\$105.00	\$31.50	\$63.00	\$21.00	\$42.00
Pay Annually	\$105.00	\$210.00	\$63.00	\$126.00	\$42.00	\$84.00

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

Dependent	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____

I wish to enroll in the AFAVBA Multi-Benefit Accident Insurance Program. I understand that this coverage will become effective on the last day of the month in which my application and correct premium are received, and I certify that I meet the veteran requirements indicated.

Signature _____

Date _____

Metropolitan Life Insurance Company Home Office: NY

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