

Convert Term to Whole Life

POLICY NUMBER(S) TO CONVERT: _____

INSURED NAME (Last, First MI): _____ **SSN:** _____

TERM AMOUNT TO RETAIN (if any): \$ _____,000 (Min \$50,000, Max current amount less amount converted)

POLICY SELECTION

POLICY (Value-Added Whole Life only): Pay to age 100 Pay for _____ years Single payment

AMOUNT: \$ _____,000 (Cannot exceed combined face amount of term policies being converted)

TOBACCO (used in last 12 months): No Yes

PREMIUM: \$ _____ per month

A deposit of TWO months premium is required.

PAYMENT: Monthly allotment from military pay
 Monthly bank account withdrawal (*include voided check*)
 Bill: Quarterly Semiannual Annual Single

PAYER: The insured Member (*if not the insured*) Other: _____
(If Other: SSN _____ Address _____)

OWNER: The insured Member (*if not the insured*) Other: _____ Relation _____
(If Other: SSN _____ Address _____)

BENEFICIARY SELECTION:

Listed below Listed on separate page (*signed and dated*)

Benefit will be paid in equal shares to the following survivors. If no beneficiaries are living, the benefit will be paid to (or to the estate of) the policy owner.

	Full name (Last, First MI)	Social Security Number	Relationship
PRIMARY(IES):	_____	_____	_____
	_____	_____	_____

CONTINGENT(S): All children of the insured (born or adopted).
 or _____

PER STIRPES: Pay the share designated to any deceased child to the surviving children of that child.

COMMON DISASTER: Delay payment until beneficiaries survive the insured by _____ days (30 max).

SETTLEMENT: Life Annuity Life Annuity with 10 years certain Interest Only Lump Sum

RESTRICTION: Beneficiaries may not change the settlement selection No restriction

A form for additional beneficiaries and uneven benefit distribution is available upon request.

CERTIFICATION: I hereby request that the Army and Air Force Mutual Aid Association convert the portion of my term life insurance policies indicated above to Value-Added Whole Life Insurance. I authorize any amount of the above term life insurance that I am not retaining to be resigned. I understand that converted coverage cannot begin until the deposit is received and this application is approved.

Insured signature _____ Date _____ / _____ / _____

Owner signature (*if not the insured*) _____ Date MM DD YYYY _____ / _____ / _____
MM DD YYYY

Please do not write in this space. Application processing at Ft. Myer, VA

Deposit Received: \$ _____ Date Received: _____ Date Accepted: _____