Application for Individual Flexible Premium Deferred Annuity with the UNITED STATES LETTER CARRIERS MUTUAL BENEFIT ASSOCIATION A Fraternal Benefit Society

100 Indiana Avenue N.W. Washington, DC 20001 • 202-638-4318

CCA Retirement Savings Plan

1. I want a CCA Retirement Savings Plan with a planned biweekly premium of:
   ☐ $15 (Minimum): ☐ $25: ☐ $35: ☐ $50: ☐ Other (Specify: $_____)
   My spouse wants a CCA Retirement Savings Plan with a planned biweekly premium of:
   ☐ $15 (Minimum): ☐ $25: ☐ $35: ☐ $50: ☐ Other (Specify: $_____)

2. NALC Member's Information: (Please print or type)

   Name _____ (First) (Middle Initial) (Last)

   Address _____

   City _____ State _____ Zip _____

   Telephone No. (_____) _____ (Area Code)

   Social Security No. _____

   NALC Branch No. _____

   Member's sex ☐ M ☐ F

   Date of Birth ____ /____ /____ (Mo / Day / Yr)

3. Information about Spouse:

   Name _____ (First) (Middle Initial) (Last)

   Sex ☐ M ☐ F

   Social Security No. _____ Date of Birth ____ /____ /____ (Mo / Day / Yr)

4. **Ownership:** The insured (annuitant) will be the policy owner of his/her policy unless otherwise specified below:
   The owner must be in accordance with the provisions in the USLCMBA Constitution General Laws – LAW 1.

   Owner _____ (First) (Middle Initial) (Last)

   Address _____

   City _____ State _____ Zip _____

   Relationship to Annuitant: _____ Social Security No. _____

5. **Will this policy be used as a:** *(Select only one option)*

   ☐ **Traditional Individual Retirement Account** ☐ **Roth Individual Retirement Account** ☐ **Non-qualified Deferred Annuity**

6. **Payroll Deduction:** I hereby authorize the U.S. Postal Service: (1) to deduct each pay period from my salary or wages such amounts as may be required by the U.S. Letter Carriers Mutual Benefit Association to pay premiums due from me for insurance and (2) to pay the amounts thereof on my behalf to the USLCMBA. The authorization shall continue during my employment in any capacity by the U.S. Postal Service until canceled by me by written notice to the USLCMBA.

   Note: By signing below, you authorize deduction of your premium unless you check box below. Payroll deductions start approximately 28 days after receipt of your application. **I do not want to use payroll deduction** *(check one)*: ☐ Bill me monthly ☐ Bill me annually

7. **Beneficiary:** The beneficiary(ies) named below of this policy application will receive the proceeds when the insured dies:

Name	Address	Relationship	Social Security No

   If you need additional space, use a separate page.

8. **Effective Date:** Your plan will be effective on the date the first premium for the plan is deducted from member's pay, or if you pay MBA directly, on the first day of the month following the receipt of your first payment.

9. **Replacement:** Do you have existing life insurance or annuity contracts? ☐ Yes ☐ No
   Is this policy (are these policies) intended to replace or change any existing life insurance or annuity policy? ☐ Yes ☐ No

   If yes, indicate:

   Name of Insurance Co. _____ Policy No. _____

Fraud Notice - For your protection California law requires the following to appear on this form: **Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

I (we) understand and agree that this application as completed and signed will form the basis of the policy (policies) issued.

_____ Date _____
Proposed Insured's Signature

_____ Date _____
Member Applicant's Signature

Do Not Write Below

USPS Finance Number _____

St. Code _____