

# WAEPA Associate Membership

## For Family of WAEPA Members

Cover  
Your  
Family.

...See **Page 2**

Most  
Popular Plans.

...See **Page 3**

Apply  
Now!

...See **Page 4**

## Why Your Family Needs Insurance...

Life insurance secures your family against the financial impact of losing a loved one including:

- Loss of income
- Funeral costs and other expenses
- Outstanding debts

Often times, families only insure the primary wage earner, and neglect to consider the financial burden they would suffer due to the loss of a secondary wage earner, or a spouse working in the home as a caretaker or a homemaker.

Your WAEPA benefit will see your family through the immediate difficulties following a death, and provide a foundation for long-term financial security.

**See inside to learn how little peace of mind for your loved ones can cost.**

## Extending WAEPA Membership To Your Non-Dependent Adult Relatives...

Wouldn't it be great if your adult family members could join WAEPA and save on life insurance just like you? In fact, they can – as WAEPA Associate Members.

As Associate Members, your relatives can purchase their own coverage just like any other WAEPA member.

Associate Membership is perfect when you need more than dependent coverage for your spouse – or to help your family get more coverage at a lower cost.

**See page 2 for details on WAEPA Associate Membership.**

### The Bottom Line:

**WAEPA Helps You Protect Your Family at the Lowest Possible Cost.**



## WAEPA Insurance

# For your Family...

### Associate Membership: How it Works

WAEPA Associate Membership is open to eligible adult relatives of WAEPA members, including:

- Spouses, domestic partners, non-dependent adult children and stepchildren, parents, and parents-in-law

As Associate Members, your relatives enjoy all the privileges and benefits of joining WAEPA, including:

- Personal life insurance coverage up to \$750,000
- Dependent life insurance coverage for spouses, domestic partners and children
- More coverage options at a lower cost
- Eligibility for future premium refunds

Even if you don't wish to purchase insurance yourself, you can still join WAEPA (for a \$2.00 fee) and enable your eligible family members to become Associate Members. Associate Membership is permanent – your relatives remain full members even if you leave WAEPA.

### Additional Benefits and Flexibility

In addition to life insurance, WAEPA Associate Membership also includes these benefits:

- Accidental death and dismemberment coverage
- Free common carrier coverage

We also allow Associate Members to:

- Adjust their coverage at any time
- Keep their coverage until age 85
- Extend Associate Membership to other eligible relatives

Through its Associate Membership program, WAEPA makes saving on life insurance contagious!

For example – the spouse or non-dependent adult children of a WAEPA member can become Associate Members (even if neither the spouse nor the non-dependent adult children work for the government). Once the non-dependent adult children join WAEPA, they too can extend Associate Memberships to their eligible family members.

### Better Insurance. Better Prices. Better Value... Why WAEPA?

WAEPA is a non-profit association (not an insurance company) formed during World War II by federal employees, for federal employees. Since that time, we've been helping our members and their families pay less for life insurance while giving them more coverage options for their money.

Ensuring their financial security at the lowest possible cost has been our mission – and our honored commitment – since 1943.



## Associate Members

# Most Popular Plans...

Member Life Insurance Schedule of Benefits									
Levels	2	4	8	12	16	20	24	28	30
Life Insurance	\$50,000	\$100,000	\$200,000	\$300,000	\$400,000	\$500,000	\$600,000	\$700,000	\$750,000
AD & D	\$10,000	\$20,000	\$40,000	\$60,000	\$80,000	\$100,000	\$120,000	\$140,000	\$150,000
Common Carrier	\$20,000	\$40,000	\$80,000	\$120,000	\$160,000	\$200,000	\$240,000	\$280,000	\$300,000
Quarterly Premiums Based on Member/Associate Member's Age									
Under 25	\$6.00	\$12.00	\$24.00	\$36.00	\$48.00	\$60.00	\$72.00	\$84.00	\$90.00
25-29	\$7.50	\$15.00	\$30.00	\$45.00	\$60.00	\$75.00	\$90.00	\$105.00	\$112.50
30-34	\$8.50	\$17.00	\$34.00	\$51.00	\$68.00	\$85.00	\$102.00	\$119.00	\$127.50
35-39	\$10.00	\$20.00	\$40.00	\$60.00	\$80.00	\$100.00	\$120.00	\$140.00	\$150.00
40-44	\$14.00	\$28.00	\$56.00	\$84.00	\$112.00	\$140.00	\$168.00	\$196.00	\$210.00
45-49	\$20.00	\$40.00	\$80.00	\$120.00	\$160.00	\$200.00	\$240.00	\$280.00	\$300.00
50-54	\$30.50	\$61.00	\$122.00	\$183.00	\$244.00	\$305.00	\$366.00	\$427.00	\$457.50
55-59	\$46.50	\$93.00	\$186.00	\$279.00	\$372.00	\$465.00	\$558.00	\$651.00	\$697.50

Please visit [www.waepa.org](http://www.waepa.org) for a complete listing of benefits and rates.

### Eligibility Notes

Associate Members must be a spouse, domestic partner, non-dependent adult child, parent, or parent-in-law of a current WAEPA member. Associate Members must also be United States citizens under the age of 65. Spouses may not be covered both as a dependent of a WAEPA member and as an Associate Member. If your spouse is accepted as an Associate Member, we will automatically cancel his or her dependent coverage. Children cannot be covered as dependents by both a WAEPA member and a spouse who is an Associate Member.

Life insurance premiums automatically increase as members enter new age groups. Coverage levels are limited above age 60. If a member's coverage exceeds the limit as he or she enters a new age group, it will automatically be reduced to the allowable amount. Accidental death and dismemberment (AD&D) and free common carrier coverage terminate at age 65. All WAEPA coverage terminates at age 85.

### How to Apply

Select the level of coverage that best suits your needs. Although the chart above lists just our most popular options, you can set your coverage as follows:

Coverage for you	\$25,000 to \$750,000 in \$25K increments	Provided on one low-cost policy
Coverage for your dependent spouse or domestic partner	\$10,000 to \$250,000 in \$10K increments (up to 50% of your coverage)	
Coverage for your dependent children	Up to \$25,000 available. Coverage depends on age, and is tied to level of spousal coverage	

Complete and sign the application forms enclosed in this brochure. As part of our underwriting process, we may request further information about your medical history or require you to take a medical exam.

Please sign and mail both parts of your completed application in the enclosed envelope to:

WAEPA, 433 Park Avenue, Falls Church, VA 22046

This form is to be used only if you (a civilian federal employee) are joining WAEPA so that your spouse, domestic partner\*, parent, or non-dependent adult children can join WAEPA as Associate Members, and apply for their own WAEPA life insurance, just like any other member of WAEPA.

**APPLICANT INFORMATION**

I hereby make application for membership in WAEPA by enclosing my non refundable \$2.00 membership application fee. Full-time members of the Armed Forces are not eligible for insurance or membership in WAEPA.

APPLICANT NAME: (Please Print) \_\_\_\_\_  
( First ) ( M.I. ) ( Last )

**ADDRESS:**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

I hereby certify the following: (please check each box as appropriate)

I am a civilian employee of the U.S. Government actively at work. I have been employed

by \_\_\_\_\_ since \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Department, Agency, or Bureau) (MM/DD/YY)

I am a retired civilian employee of \_\_\_\_\_  
Enclosed is a copy of my SF 50 Notification of Personnel Action (or equivalent). (Department, Agency, or Bureau)

I am a citizen of the United States of America and my Social Security Number is \_\_\_\_\_

My date of birth is \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(MM/DD/YY)

**Signature:**

X \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Applicant Signature) (MM/DD/YY)

**IMPORTANT NOTICE:**

THIS FORM IS NECESSARY ONLY IF THE CIVILIAN FEDERAL EMPLOYEE IS NOT AN EXISTING WAEPA MEMBER. IF THE CIVILIAN FEDERAL EMPLOYEE IS AN EXISTING WAEPA MEMBER, PLEASE PROCEED TO THE WAEPA APPLICATION FOR ASSOCIATE MEMBERSHIP AND LIFE INSURANCE SECTION OF THE APPLICATION (PAGES 5, 6, & 7).

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\*Domestic Partner Coverage is not available in Virginia.

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This form is to be used by spouses, domestic partners\*, parents, and non-dependent adult children of WAEPA members to apply for Associate Membership and their own WAEPA coverage. Domestic partners must also complete a Domestic Partner Affidavit. The affidavit is available at [www.waepa.org](http://www.waepa.org) or by calling 1-800-368-3484.

**APPLICANT INFORMATION**

**APPLICANT NAME:** (Please Print) \_\_\_\_\_  
 ( First ) ( M.I. ) ( Last )

I hereby make application for Associate Membership in WAEPA. If admitted to Associate Membership, I hereby make application for Group Insurance for which I am eligible, and for the Accidental Death and Dismemberment benefits under the policies issued to WAEPA by the The Life Insurance Company of North America. I understand that I cannot be covered under more than one WAEPA certificate.

I am a  Spouse/domestic partner  Non-dependent adult child  Parent  Parent-in-law  
 of \_\_\_\_\_ A WAEPA member, certificate # \_\_\_\_\_  
 (Name)

**1. Amount of insurance coverage selected.**

a. Basic Group Life Insurance (Amount of Associate Member Life Insurance) \$ \_\_\_\_\_ Level \_\_\_\_\_  
 b. Dependent Group Life (DGL) Insurance (Amount of Spouse/Domestic Partner\*/Children Life Insurance) \$ \_\_\_\_\_ Level \_\_\_\_\_  
 Note: Your spouse/domestic partner\* coverage may not be greater than one half (50%) of your coverage.

**2. Your sex:**  Male  Female

**3. Your date of birth** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
 (MM/DD/YY - You must be less than age 65)

**4. I am a citizen of the United States of America and my Social Security Number is** \_\_\_\_\_

**5. Your spouse's Social Security Number (ONLY if applying for spousal coverage)** \_\_\_\_\_

**6. I will pay premiums:**  Annually  Semi-Annually  Quarterly  Monthly

An authorization form permitting us to transfer funds from your checking account will be mailed to you.

**7. Initial Premium Payment – Send No Money!**

Once your application has been received and approved, we will advise you of the amount due. Your coverage will be effective on the date you provide evidence of insurability satisfactory to the insurance carrier, and you forward the first premium. Your payment must reach us within 30 days of the date of notification.

**8. I designate as my beneficiary** (please list legal name, e.g., Mary White Jones not Mrs. John Jones)

Primary \_\_\_\_\_ Relationship \_\_\_\_\_

Contingent \_\_\_\_\_ Relationship \_\_\_\_\_

If you name a contingent beneficiary, the contingent beneficiary will receive the death benefit if your primary beneficiary is not living when you die. If you name more than one person as a primary beneficiary or a contingent beneficiary, specify the percentage of benefit payable to each beneficiary. The applicant/member will be the beneficiary of all dependent coverage.

**9. Applicant Contact Information:**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ E-mail \_\_\_\_\_

\*Domestic Partner Coverage is not available in Virginia.

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**Underwritten by the following CIGNA companies:** Life Insurance Company of North America (LINA), Connecticut General Life Insurance Company (CG) and CIGNA Companies (herein called the Insurance Company)

APPLICANT INFORMATION						
LIST BELOW ONLY INDIVIDUALS APPLYING FOR COVERAGE	ALIAS MAIDEN NAME	RELATIONSHIP (TO APPLICANT)	BIRTH DATE (MM/DD/YY)	AGE	HEIGHT (FT. IN.)	WEIGHT (LBS.)
APPLICANT (Full Name)						
ELIGIBLE DEPENDENTS (Full Names)						

**HEALTH QUESTIONS SECTION A**

By applying for this coverage, do you intend to replace, discontinue or exchange existing life insurance coverage .....  Yes or  No

**Within the last five years, have you or your eligible dependents been:**

- diagnosed with any of the conditions shown in items A through J below,
  - told by a medical professional he/she has, or may have, any of the conditions show in items A through J below,
  - or been treated by a medical professional for any of the conditions shown in items A through J below?
- A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation, or any other condition affecting the heart or circulatory system? .....  Yes or  No
- B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver, or pancreas? .....  Yes or  No
- C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract? .....  Yes or  No
- D. Any condition affecting the kidneys, urinary tract, prostate gland, or reproductive system? .....  Yes or  No
- E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes? .....  Yes or  No
- F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system? .....  Yes or  No
- G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity, or loss of limb? .....  Yes or  No
- H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition? .....  Yes or  No
- I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps, or Moles? .....  Yes or  No
- J. Alcohol or drug abuse or dependency? .....  Yes or  No

**HEALTH QUESTIONS SECTION B**

**Within the last five years, have you or your eligible dependents:**

- A. Used any controlled or illegal drug or other substance? .....  Yes or  No
- B. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams? .....  Yes or  No
- C. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture? .....  Yes or  No
- D. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above? .....  Yes or  No

USE THE SPACE BELOW TO EXPLAIN "YES" ANSWERS. IF MORE SPACE IS NEEDED, USE A NEW PAGE, SIGN AND DATE IT AND ATTACH TO THIS FORM.

Name of Person	Condition	Date Occurred	Duration/Treatment Received	Current Status

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**Caution:** Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

PHYSICIAN SECTION			
	Name	Contact Information	Street Address (City, State, & Zip)
Applicant Physician		Tel# Fax#	
Spouse/Domestic Partner Physician		Tel# Fax#	
Child(ren) Physician		Tel# Fax#	

**AGREEMENTS AND AUTHORIZATION**

To the best of my knowledge and belief, all written, telephonic, and electronic information I gave is true and complete. I also understand that coverage for each of my dependents will not go into effect if a dependent is confined in a hospital or institution. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical information.
- (3) I may need to take medical tests and report the results to the Insurance Company.
- (4) My dependent(s) may need to take medical tests. The results of those tests must be reported to the Insurance Company.
- (5) I must report any change in my health, or of a dependent for whom coverage is requested, that happens before the insurance is effective.
- (6) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

**AUTHORIZATION**

I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, or any other person or organization having information about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me or my children to disclose to the Insurance Company or its authorized agent, any such information, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the information will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with the applicable law.

I understand that the information provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

X \_\_\_\_\_  
Applicant's Signature Date

X \_\_\_\_\_  
Signature of Spouse/Domestic Partner (if applying) Date

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

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## Better Life Insurance For Families of Federal Employees

- Enable your spouse and non-dependent adult children to become WAEPA Associate Members
- Extend to them the full benefits of joining WAEPA
- Help them purchase more coverage (up to \$750,000) for less
- Get more coverage for your spouse



**Help Your Family Save on  
Life Insurance... See Inside!**

**WAEPA Members:**

**www.WAEPA.org**  
433 Park Avenue  
Falls Church, VA 22046

**Better Insurance. Better Prices. Better Value.®**