

# Rate Information

## Affordable Life Coverage

By using the charts below, calculate your monthly life insurance premium based on your current age, loan balance and if you have used any tobacco products in the last 24 months.

To figure out your premium if applying for **single** coverage, round your

mortgage loan balance to the next highest \$1,000 (i.e., if your loan balance is \$49,500, round it up to \$50,000). Then select the cost per \$1,000 from the charts below using your age. Multiply this cost by your loan balance to determine your monthly premium cost.

For example, if your loan balance is \$50,000, and you are 34, a non-tobacco user and want single life coverage, your cost would be \$9.50 per month.

Example: 50 (thousand) x .19 (cost per \$1,000) = \$9.50 (monthly premium)

If applying for **joint** coverage, your monthly rate is determined by the age of the **older** person. Also, if either of you have used tobacco products in the last 24 months, you would use the Tobacco User rates.

For example, your loan balance is \$50,000, you're 34, your co-borrower is 39, and **one** or **both** of you are a tobacco user. Your monthly premium would be \$31.00.

Example: 50 (thousand) x .62 (cost per \$1,000) = \$31.00 (monthly premium)

This is the monthly life premium charge, which should be entered in Section C of your application.

## How to Enroll

### SEND NO MONEY

- A) Fill out the personal identification information selection.
- B) Answer the medical questions.
- C) Indicate the coverages you'd like and the amount(s).
- D) Sign and date the application. Detach the form, fold, tape and drop it in the mail.

After we process your application, we will notify you of the policy's effective date.

A medical exam may be required.

**Want help calculating your rate?  
Just call 1-800-356-6006.**

Age	Monthly Premium Rates Per \$1,000 of Initial Life Coverage SINGLE COVERAGE		JOINT COVERAGE	
	Non-Tobacco	Tobacco User	Non-Tobacco	Tobacco User
0-24	0.14	0.20	0.21	0.30
25-29	0.15	0.23	0.23	0.35
30-34	0.19	0.29	0.29	0.44
35-39	0.25	0.41	0.38	0.62
40-44	0.37	0.64	0.56	0.96
45-49	0.55	0.96	0.83	1.44
50-54	0.78	1.34	1.17	2.01
55-59	1.15	1.97	1.73	2.96
60-64	1.78	3.04	2.67	4.56
65-69	2.83	4.84	4.25	7.26

## Affordable Disability Coverage

To calculate your monthly premium charge, round your monthly mortgage payment to the next whole dollar. Then multiply this by the appropriate rate shown in the table below.

If you are applying for joint coverage, use the age of the older person.

If life and disability benefits are applied for, the minimum amount of life insurance that may be applied for is 50% of the initial amount of the mortgage loan.

## Loan Term and Coverage Variations

This is an outline of the MEMBERS Home Mortgage Protection Insurance Plan. All the coverage

details are contained in the actual Certificate, which will be mailed to you upon approval of your application.

- The minimum loan term is 10 years and the maximum amount of insurance is \$450,000.
- Insurance may be applied for on any secured closed-end loan.
- There is no express or implied guarantee, warranty or indemnity on behalf of the credit union for the services promoted.
- Benefits are paid directly to the group policyholder.

as a pilot, crew member or passenger on a scheduled flight on a commercial airline. In addition, disability benefits will not be paid for normal pregnancy, participation in a riot, crime or felony.

### These benefits begin after a 30-day waiting period.

Age Last Birthday	Rates	Monthly Mortgage Payment	Monthly Premium
Under 45	.04 x	_____ = \$	_____
45-55	.05 x	_____ = \$	_____

This is the monthly disability premium charge which should be entered in Section C.

### EXCLUSIONS

Life and disability benefits are not payable due to death or disability caused from suicide, while sane or insane, within two years after becoming insured under the policy; intentionally self-inflicted injury; an act of war; or air travel other than

## Consumer Privacy Notice

### NOTICE TO APPLICANT: YOUR PRIVACY IS PROTECTED

In order to evaluate your application for insurance, CUNA Mutual Insurance Society or its reinsurers may ask for medical or other personal information about you and any other person to be insured from medical professionals, or the Medical Information Bureau, Inc.

Information we collect about you will not be given to anyone without your consent, except when necessary to conduct our business. A brief report may be made to the Medical Information Bureau, a nonprofit membership organization of life

insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance, or a claim is submitted to such a company, the Bureau will, upon request, supply such company with information in its file. CUNA Mutual or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for insurance, or to affiliated companies, or to whom a claim for benefits may be submitted.

If you ask, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address

of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Upon written request to CUNA Mutual Insurance Society, you may have access to the information about you in your file. If after reading the information in your file, you believe it is inaccurate, you should notify us, indicating what you believe is inaccurate and why. We will tell you at that time how to correct or amend your file and when information may be disclosed to others without your consent.

Also as part of our normal procedure for processing your application, an investigative consumer report or other consumer report may be prepared. In an investigative consumer report information is obtained through personal interviews with your

neighbors, friends, or others with whom you are acquainted. This inquiry, if obtained, typically includes information as to your character, general reputation, and mode of living. You may make a written request within a reasonable period of time for additional information about the nature and scope of this investigation.

If you ask, you may be interviewed by the agency preparing your report. Information you give to the agency will be included in the report sent to us. If you wish to be interviewed, please tell us how the consumer reporting agency can reach you. Every effort will be made by the consumer reporting agency to interview you. However, if they cannot contact you, you may ask them to mail you a copy of the report.

Please direct any request for information to our Underwriting Department.

### REJECTION STATEMENT

I/We had the opportunity to apply for the group mortgage insurance plan, but do not want this coverage.  
I/We understand that by signing this "Rejection Statement," I/we may still apply for mortgage insurance in the future.

X  X   
SIGNATURE OF BORROWER #1 DATE SIGNATURE OF BORROWER #2 DATE

# MEMBERS HOME MORTGAGE PROTECTION APPLICATION

## GROUP MORTGAGE INSURANCE

PLEASE PRINT

CERTIFICATE NO. \_\_\_\_\_

**(A)** Name \_\_\_\_\_ Borrower #1 \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 Daytime Phone (\_\_\_\_\_) \_\_\_\_\_  
 Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F  
 Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Credit Union Name Covantage Credit Union  
 Secondary Beneficiary/Address/Relationship/Date of Birth \_\_\_\_\_

Name \_\_\_\_\_ Borrower #2 (Must be obligated on the loan to apply for joint coverage)  
 Mailing Address \_\_\_\_\_  
 Daytime Phone (\_\_\_\_\_) \_\_\_\_\_  
 Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F  
 Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Secondary Beneficiary/Address/Relationship/Date of Birth \_\_\_\_\_

**(B)** Borrower #1  
 Yes  No   
 Yes  No   
 Yes  No   
 Yes  No

1. Have you ever been treated for or diagnosed by a member of the medical profession as having any of the following: (Please check the box and circle condition(s) that applies.)  
 Diabetes; high blood pressure; chest pain; heart, blood, blood vessel, lung or breathing disorders; cancer; epilepsy; stroke; pneumonia(s); arthritis; brain, mental, nervous, back, neck, joint or muscular disorders; stomach, intestines, liver, pancreas, or kidney disorders; cirrhosis, drug or alcohol abuse; acquired immune deficiency syndrome or AIDS related complex, or tested positive for antibodies to the AIDS virus? (NOTE TO RESIDENTS OF ME, ND, VT AND WI: You do not have to disclose positive test results for the antibodies to the AIDS Virus.)
  2. During the past 3 years, have you for any reason been hospitalized?
  3. Have you used tobacco in any form within the past 24 months?
- If Disability Coverage is Requested —**
4. Are you now gainfully employed on a full-time basis and presently working 25 hours a week or more?

Name and Address of Family Physician \_\_\_\_\_

GIVE FULL DETAILS BELOW FOR ANY HEALTH PROBLEM INDICATED IN THIS SECTION

Name of Person	Name & Address of Physician	Nature of Condition	Dates & Duration

**(C) LIFE COVERAGE:**  Single  Joint  
 1. Amount of Insurance Requested ..... \$ \_\_\_\_\_  
(Your loan balance, up to \$450,000)  
 2. Life Insurance Charge ..... \$ \_\_\_\_\_  
(Refer to rate table.)

**DISABILITY COVERAGE:**  Single  Joint  No Coverage  
 1. Amount of Insurance Benefit Requested ..... \$ \_\_\_\_\_  
(Your monthly payment, up to \$2,000 for single and \$3,000 for joint coverage)  
 2. Disability Insurance Charge ..... \$ \_\_\_\_\_  
(Refer to rate table.)

NOTE: You must apply and be approved for LIFE to be eligible for DISABILITY coverage. If you select **Joint Disability**, coverage and benefits will be split equally between Borrower #1 and #2. If the insurance you applied for is approved, it will become effective on the date of approval or, if later, the effective date of the loan as shown on this Application.

**(D) CONSUMER PROTECTIVE AUTHORIZATION**  
**Consumer Authorization Form**

These answers are true and complete to the best of my knowledge and belief. To determine my insurability, or for claims purposes, I authorize any medical practitioner or institution, insurance company or the Medical Information Bureau, Inc., Consumer Reporting Agency, or employer to give any information about my physical or mental health condition, treatment, or any non-medical information to CUNA Mutual Insurance Society, or its reinsurer. I agree that this authorization shall be valid for 30 months from the application date. I have read the Consumer Privacy Notice pertaining to the Medical Information Bureau as required by the Fair Credit Reporting Act. The Society shall incur no liability until this application is approved by the Society and the first premium paid. By signing this application I acknowledge that I understand that this policy contains a war exclusion. **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

I authorize my financial institution to pay my insurance premiums as indicated above to CUNA Mutual Insurance Society by Electronic Funds Transfer from my credit union account  Savings or  Checking (select one and indicate account number \_\_\_\_\_). As my financial institution you will be fully protected in honoring these payments until you receive written notice from me cancelling this request.

**X** \_\_\_\_\_  
 SIGNATURE OF BORROWER #1 DATE

**X** \_\_\_\_\_  
 SIGNATURE OF BORROWER #2 DATE

B3f-902-0394

B3d-900-0987

**(E) TO BE COMPLETED BY LENDER OR SERVICING FIRM**  
 Contract No. 0 4 8 - 0 6 2 4 - 2  
 Original Loan Term \_\_\_\_\_  
 Current Loan Balance \_\_\_\_\_  
 Loan Effective Date \_\_\_\_\_  
 Loan Number \_\_\_\_\_  
 If this member currently has an existing HMP certificate, is this application to replace the existing coverage?  Yes  No

Mortgageholder's Name \_\_\_\_\_  
 Date Last Payment Was Made \_\_\_\_\_  
(If New, Date of First Payment)  
 Monthly Principal And Interest \_\_\_\_\_  
 Total Monthly Mortgage Payment \_\_\_\_\_  
 Interest Rate \_\_\_\_\_

I/we understand that this insurance is optional and is not a condition or requirement for approval of my/our loan. My monthly premium will be \$ \_\_\_\_\_ x 12 = an estimated annual premium of \$ \_\_\_\_\_.

Detach, fold, tape, mail. Postage is paid.