National Guard State Sponsored Life Insurance (SSLI) Plan for Members of the Wisconsin National Guard Association (WINGA)
Provided through Armed Forces Benefit Association (AFBA)
Multi-Association Group Insurance Alliance Trust (MAT)

Guard Member Information

Guard Member Name: _____ (Last) _____ (First) _____ (Middle)

Mailing Address: _____ _____ (City) _____ (State) _____ (Zip Code)

Phone Number: ( ) _____ - _____ Email: _____

Guard Member Social Security Number (SSN): _____ - _____ - _____ Date of Enlistment: _____ / _____ / _____ (MM / DD / YYYY)

Date of Birth: _____ / _____ / _____ (MM / DD / YYYY) Sex: ❒ Male ❒ Female ❒ Army ❒ Air-Milwaukee ❒ Air-Madison/Volk

Beneficiary Designation

I hereby make the following beneficiary designation with respect to all the insurance on my life under this State Sponsored Life Insurance Plan.

_____ (Beneficiary Name (Last, First, Middle)) _____ (Relationship to Member) Date of Birth: _____ / _____ / _____ (MM / DD / YYYY)

❒ **I HEREBY APPLY FOR $10,000 OF COVERAGE UNDER A GROUP TERM LIFE INSURANCE POLICY AT NO COST TO ME FOR ONE YEAR. Coverage is paid by WINGA.**

Is the insurance applied for intended to replace, discontinue, or change an existing policy? ❒ Yes ❒ No

Read and Sign

Please read the following statements carefully.

MEMBER DECLARATION:
I declare that I have joined the National Guard of Wisconsin within the past 120 days and that I am currently an active guard member. I request the above indicated amount of insurance and understand that coverage will be effective the day the Plan Administrator receives this application provided the premium is paid when due by the WINGA.

By signing and dating this application, the member requests the insurance indicated; attests to having read the Fraud Notice indicated below, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

FRAUD NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the law.

_____ (Member Signature) _____ / _____ / _____ (Date)

Note: The maximum amount of coverage available with this request is $10,000 per member. To apply for higher amounts of coverage for you and/or your dependents, contact WINGA.

For more information visit: www.winga.org/insurance.html
Admin.office: WINGA Insurance Plan (SSLI)
2400 Wright St., Madison, WI 53704-2572
P (608) 242-3100 | F (608) 242-3106
email: insinfo@winga.org | www.winga.org/insurance.html

Member death benefits provided by AFBA are underwritten by 5Star Life Insurance Company (a Lincoln, Nebraska company) with an administrative office at 909 N. Washington Street, Alexandria, VA 22314. Member death benefits not available in all states and U.S. territories.