



# POLISH ROMAN CATHOLIC UNION OF AMERICA

A Fraternal Benefit Society

984 North Milwaukee Avenue, Chicago, IL 60642-4101  
(800) 772-8632 • 773-782-2600 • Fax 773-782-2733 • [www.PRCUA.org](http://www.PRCUA.org)  
new-business@prcu.org

## EXPRESS LIFE APPLICATION

### PROPOSED INSURED'S INFORMATION

Adult  Juvenile

1. \_\_\_\_\_

SOCIETY

CERTIFICATE - HOME OFFICE USE

ROSTER - HOME OFFICE USE

2. \_\_\_\_\_  
NAME (FIRST, MI, LAST NAME)

3. \_\_\_\_\_  
STREET ADDRESS / CITY, STATE, ZIP CODE

4. Sex:  Male  Female 5. \_\_\_\_\_

DATE OF BIRTH

6. \_\_\_\_\_

AGE

7.  SSN  TIN  EIN # \_\_\_\_\_

8. \_\_\_\_\_

OCCUPATION

9. \_\_\_\_\_

EMAIL ADDRESS

10. \_\_\_\_\_

TELEPHONE NUMBER

11. \_\_\_\_\_ 12. \_\_\_\_\_ 13. \_\_\_\_\_

PROPOSED INSURED'S DRIVER'S LICENSE NUMBER / STATE IDENTIFICATION NUMBER

STATE ISSUED

EXPIRATION DATE

### OWNER'S INFORMATION (IF OTHER THAN PROPOSED INSURED)

14. \_\_\_\_\_ 15. \_\_\_\_\_  
NAME (FIRST, MI, LAST NAME) RELATIONSHIP TO PROPOSED INSURED

16.  SSN  TIN  EIN # \_\_\_\_\_

17. \_\_\_\_\_ 18. \_\_\_\_\_  
EMAIL ADDRESS TELEPHONE NUMBER

### PLAN INFORMATION

19. \_\_\_\_\_ 20. \_\_\_\_\_  
PLAN OF INSURANCE AMOUNT OF INSURANCE

21. Premium \$ \_\_\_\_\_ 22. Mode:  Single  Annual  Semi-Annual  Quarterly  Monthly

23. Riders\*:  GIO  ADB  WP  JPB \*Not all riders are available with all plans 24.  ACH (complete form ACH1)

25. In the event of default in payment of any premium due, shall the automatic premium loan provision, if applicable, become effective in lieu of any non-forfeiture option?  Yes  No

26. Is this insurance intended to replace any now in force?  Yes  No 27. Is Proposed Insured a PRCUA Member?  Yes  No

28. Dividend Election (choose one):  Paid in Cash  Purchase Paid-Up Additions

### BENEFICIARY INFORMATION

29. PRIMARY (Name) \_\_\_\_\_  
 SSN  TIN  EIN # \_\_\_\_\_ Relationship \_\_\_\_\_

30. CONTINGENT (Name) \_\_\_\_\_  
 SSN  TIN  EIN # \_\_\_\_\_ Relationship \_\_\_\_\_

### APPLICANT'S INFORMATION (IF OTHER THAN PROPOSED INSURED OR OWNER)

31. \_\_\_\_\_ 32. Sex:  Male  Female  
NAME (FIRST, MI, LAST NAME)

33. \_\_\_\_\_ 34. \_\_\_\_\_  
STREET ADDRESS / CITY, STATE, ZIP CODE RELATIONSHIP TO PROPOSED INSURED

35. \_\_\_\_\_ 36. \_\_\_\_\_  
EMAIL ADDRESS TELEPHONE NUMBER

37. \_\_\_\_\_ 38. \_\_\_\_\_ 39. \_\_\_\_\_  
APPLICANT'S DRIVER'S LICENSE NUMBER / STATE IDENTIFICATION NUMBER STATE ISSUED EXPIRATION DATE

### PROPOSED INSURED'S HEALTH INFORMATION

40. \_\_\_\_\_ 41. \_\_\_\_\_  
HEIGHT / WEIGHT DOCTOR'S NAME / STREET ADDRESS / TELEPHONE NUMBER

42. In the past 5 years, has the Proposed Insured been treated for, or been diagnosed by physician for any medical or surgical condition including cancer, heart condition, kidney and liver disease, vascular disease, diabetes, muscular condition, stroke, elevated cholesterol, or drug and alcohol dependency?

Yes  No

43. Is Proposed Insured currently hospitalized, bedridden, or confined to a wheel chair?

Yes  No

44. Has Proposed Insured used any form of tobacco in the last 12 months?

Yes  No

PROPOSED INSURED'S HEALTH INFORMATION (continued from page 1)

If you answered "Yes" to questions 42-44 on page 1, explain details below. Attach a separate page if additional space is needed.

Table with 3 columns: Date, Name & Address of Physician & Hospital, Specific Reason & Results

AGREEMENT - AUTHORIZATION - ACKNOWLEDGMENT - SIGNATURES

This authorization complies with the HIPAA Privacy Rule.

I understand I can revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by giving written notice to the Polish Roman Catholic Union of America (PRCUA) at the name and address shown above.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, MIB LLC, ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give the PRCUA, or its representatives, including Equifax or bearer, or reinsurer, any such information. The PRCUA may disclose such information to its reinsurer(s), MIB or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize.

1) AGREE that the statements and answers contained in this application are complete and true to the best of my knowledge and belief. 2) AGREE to abide by the Articles of Incorporation, Constitution, By-Laws, Rules and Regulations of the Union, which are now in force or may hereafter be adopted by the Union. 3) AGREE that the insurance applied for will become effective when the first premium due is paid and while the Proposed Insured's health, habits and occupation remain as described in this application on the date of issuance of a life certificate by the Union. 4) AGREE that if I am not a member of the Union, this application serves as a membership application.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. Any certificate issued as a result of material misstatement or omission of facts may be voided and the company's only obligation shall be to return the premiums paid.

I understand that an Illustration conforming to the issued certificate will be provided to me at the time of delivery of the certificate. It will then be signed, returned to the PRCUA Home Office, and become part of my application for membership.

SIGNED AT \_\_\_\_\_ THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_
CITY / STATE DAY MONTH YEAR

PROPOSED INSURED'S SIGNATURE (MUST BE 16 YEARS OR OLDER) APPLICANT'S SIGNATURE, IF OTHER THAN PROPOSED INSURED

OWNER'S SIGNATURE, IF OTHER THAN PROPOSED INSURED OR APPLICANT AGENT'S SIGNATURE / AGENT'S FLORIDA LICENSE ID NUMBER OR HOME OFFICE SIGNATURE

AGENT'S NAME

AGENT'S STATEMENT: To the best of my knowledge this insurance applied for \_\_\_\_\_ will \_\_\_\_\_ will not replace any existing life insurance or annuity. I further certify that any information recorded by me on the application is true and accurate to the best of my knowledge.

AGENT'S SIGNATURE / AGENT'S FLORIDA LICENSE ID NUMBER DATE

SECONDARY ADDRESSEE: (for notification of past due premium payment and possible lapse in coverage)
Address \_\_\_\_\_
Street City State Zip

HOME OFFICE APPROVAL - HOME OFFICE USE ONLY

NOTICE OF INFORMATION PRACTICES

This Notice Must be Given to Proposed Insured

(Including MIB Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING MIB, LLC ("MIB")

Information regarding your insurability will be treated as confidential. Polish Roman Catholic Union of America, or its Reinsurer(s) may, however, make a brief report thereon to the MIB, a not-for profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of information it may have in your file by calling (866) 692-6901 or you can go to their website www.mib.com. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

POLISH ROMAN CATHOLIC UNION OF AMERICA, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**SALES REPRESENTATIVE REPORT**

1. Has any insurance or annuity in force or applied for on the life of the proposed annuitant terminated within the past three months or is termination of such insurance or annuity contemplated as a result of the issuance of the annuity applied for?

- Yes       No

If yes, have you complied with the Union’s and your state’s requirements regarding replacement?

- Yes       No

2. Have you issued a receipt with this application?

- Yes       No

3. REMARKS/SPECIAL REQUESTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that on the date shown below:

- 1. The application was completed and signed in my presence by the proposed annuitant, or the owner, if other than the proposed annuitant;
- 2. I have asked each question on the application and I have honestly and accurately recorded the answers supplied by the proposed annuitant, or the owner, if other than the proposed annuitant.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SALES REPRESENTATIVE’S SIGNATURE & CODE (MUST BE SIGNED IN EVERY CASE)

\_\_\_\_\_  
SALES REPRESENTATIVE’S PHONE NUMBER

\_\_\_\_\_  
SALES REPRESENTATIVE’S EMAIL ADDRESS