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
new-business@prcua.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.** _____ Proposed Insured's Driver's License Number / State Identification Number **12.** _____ State Issued **13.** _____ Expiration Date

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

**14.** _____ Name (First, MI, Last Name) **15.** _____ Relationship to Proposed Insured

**16.** ☐ SSN ☐ TIN ☐ EIN # _____

**17.** _____ Email Address **18.** _____ Telephone Number

## PLAN INFORMATION

**19.** _____ Plan of Insurance **20.** _____ 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.** _____ Name (First, MI, Last Name) **32.** Sex: ☐ Male ☐ Female

**33.** _____ Street Address / City, State, Zip Code **34.** _____ Relationship to Proposed Insured

**35.** _____ Email Address **36.** _____ Telephone Number

**37.** _____ Applicant's Driver's License Number / State Identification Number **38.** _____ State Issued **39.** _____ Expiration Date

## PROPOSED INSURED'S HEALTH INFORMATION

**40.** _____ Height **41.** _____ Weight **42.** _____ Doctor's Name

**43.** _____ Doctor's Street Address / City, State, Zip Code **44.** _____ Doctor's Phone Number

**45.** Is Proposed Insured currently hospitalized, bedridden, or confined to a wheel chair? ☐ Yes ☐ No

**46.** In the past 5 years, has the Proposed Insured had or been treated for, or been advised to obtain treatment for 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

**47.** 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 **45**-**47** on page 1, explain details below. Attach a separate page if additional space is needed.

| Date | Name & Address of Physician & Hospital | Specific Reason & Results |
|---|---|---|
| | | |
| | | |
| | | |

## AGREEMENT - AUTHORIZATION - ACKNOWKEDGMENT - 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 at the name and address shown above.**

**AUTHORIZE** any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy benefits manager, insurance support organization, pharmacy/government agency, insurance or reinsuring company, consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company, or its reinsurers, to release any information including my personal health information obtained to reinsuring companies, 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. I authorize MIB, LLC, and any MIB member insurer, to provide any medical or personal information that it has about me to PRCUA, its reinsurer or any MIB-authorized third-party administrator performing underwriting services on PRCUA's behalf. I also authorize PRCUA, its reinsurer or authorized third-party administrator, to make a brief report of my personal health information to MIB, LLC. As to this authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 24 months from the date shown below. I know that I or my representative may request a copy of this authorization. It is understood that Polish Roman Catholic Union of America underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company, or its reinsurer, (or the Company, or its reinsurers, becomes obligated to report such codes to MIB) while this authorization is in force. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage.

**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.

**ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION: POLISH ROMAN CATHOLIC UNION OF AMERICA IS LICENSED TO DO BUSINESS IN THE STATE OF ILLINOIS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN THE ILLINOIS LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOWN AS THE GUARANTY ASSOCIATION). THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE (POLICY) HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE (POLICY) ISSUED BY THE SOCIETY.**

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

_____ SALES REPRESENTATIVE'S SIGNATURE / CODE OR HOME OFFICE SIGNATURE

_____ 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