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

LIFE INSURANCE APPLICATION

A - PROPOSED INSURED'S INFORMATION

1. New Member: ☐ Yes ☐ No **2.** __________ ______________________ ____________ ☐ Medical Required
Society — Certificate - HOME OFFICE USE — Roster - HOME OFFICE USE

3. ______________________________ **4.** Sex: ☐ M ☐ F
Name (First, MI, Last Name)

5. ______________________________
Street Address / City, State, Zip Code

6. Marital Status: ☐ Single ☐ Married ☐ Widowed **7.** ______________ **8.** ________ **9.** ______________
Date of Birth — Age — Birthplace (State / Country)

10. ☐ SSN ☐ TIN ☐ EIN # ______________________________

11. ______________________________ **12.** ______________________________
Email Address — Telephone Number

13. ______________________________ **14.** ______________________________
Employer's Name, Street Address / City, State, Zip Code — Occupation

15. ______________________________ **16.** ________ **17.** ______________
Proposed Insured's Driver's License Number / State Identification Number — State Issued — Expiration Date

B - OWNER'S INFORMATION (IF OTHER THAN PROPOSED INSURED)

18. ______________________________ **19.** Sex: ☐ M ☐ F **20.** ______________
Name (First, MI, Last Name or Name of Trust) — Date of Birth

21. ______________________________ **22.** ______________________________
Street Address / City, State, Zip Code — Relationship to Proposed Insured

23. ☐ SSN ☐ TIN ☐ EIN # ______________________________

24. ______________________________ **25.** ______________________________
Email Address — Telephone Number

26. ______________________________ **27.** ________ **28.** ______________
Driver's License Number / State Identification Number — State Issued — Expiration Date

29. ______________________________ **30.** ______________________________
If Certificate is Trust Owned, Complete Name of Trustees — Date of Trust (Attach All Trust Pages)

C - APPLICANT'S INFORMATION (IF OTHER THAN PROPOSED INSURD OR OWNER)

31. ______________________________ **32.** Sex: ☐ M ☐ F **33.** ______________
Name of Applicant (First, MI, Last Name) — Date of Birth

34. ______________________________ **35.** ______________________________
Street Address / City, State, Zip Code — Relationship to Proposed Insured

36. ☐ SSN ☐ TIN ☐ EIN # ______________________________

37. ______________________________ **38.** ______________________________
Email Address — Telephone Number

39. ______________________________ **40.** ______________ **41.** ______________
Driver's License Number / State Identification Number — State Issued — Expiration Date

D - PLAN INFORMATION

42. Plan ______________________________ **43.** Face Amount $______________

44. Premium $______________ **45.** Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly **46.** ☐ ACH (complete form ACH1)

47. Riders*: ☐ GIO ☐ ADB ☐ WP ☐ JPB ** Not all riders are available with all plans*

48. In the event of a 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

49. Dividend election (choose one): ☐ Cash ☐ Purchase Paid-Up Additions **50.** Billing Address: ☐ Insured ☐ Owner ☐ Applicant

E - ADDITIONAL LIFE INSURANCE INFORMATION

51. Has the Proposed Insured ever had an application for life insurance declined, postponed, rated or modified? ☐ Yes ☐ No
If yes, provide details: ______________________________

52. Excluding this application, amount of insurance currently pending with other companies (If none, write "None"): ______________

53. Of the above pending amount, how much do you intend to accept? $______________

54. List all insurance now in force, or pending, including PRCUA. (If none, write "None"). Have you, or do you intend to have any life insurance replaced, converted, reissued, or otherwise discontinued because of this application? If "Replacing", complete Replacement Form.

COMPANY	CERTIFICATE#	FACE AMOUNT	ISSUE DATE	ADB	REPLACING?	1035 EXCHANGE?
__________	__________	$__________	__________	$______	☐ Yes ☐ No	☐ Yes ☐ No
__________	__________	$__________	__________	$______	☐ Yes ☐ No	☐ Yes ☐ No

55. Do you, the Applicant, have any existing annuity contracts or life insurance policies? ☐ Yes ☐ No
If Yes, Company Name: ______________________________

AGENT

56. Does the Applicant have any existing annuity contracts or life insurance policies? ☐ Yes ☐ No
If Yes, Company Name: ______________________________

57. To the best of your knowledge, is this individual annuity or individual life insurance policy applied for intended to replace or change, in whole or in part, any existing insurance or annuities with this or any other insurer? ☐ Yes ☐ No

I certify that the information provided by the owner has been accurately recorded; no written sales materials other than those approved by the company were used; and I have reasonable grounds to believe the purchase of the contract applied for is suitable for the owner.

______________________ ______________ ______________________
(PRINT) SALES REPRESENTATIVE'S NAME CODE SALES REPRESENTATIVE'S SIGNATURE

F - BENEFICIARY INFORMATION

Attach First & Last Page of Trust

58. PRIMARY (Name) ______________________ Relationship __________ % Share _____
Trustees (if applicable) ______________________
☐ SSN ☐ TIN ☐ EIN # ______________________ Birth/Trust Date ______________
PRIMARY (Name) ______________________ Relationship __________ % Share _____
Trustees (if applicable) ______________________
☐ SSN ☐ TIN ☐ EIN # ______________________ Birth/Trust Date ______________

59. CONTINGENT (Name) ______________________ Relationship __________ % Share _____
Trustees (if applicable) ______________________
☐ SSN ☐ TIN ☐ EIN # ______________________ Birth/Trust Date ______________
CONTINGENT (Name) ______________________ Relationship __________ % Share _____
Trustees (if applicable) ______________________
☐ SSN ☐ TIN ☐ EIN # ______________________ Birth/Trust Date ______________

G - GENERAL INFORMATION (IF YES, PROVIDE DETAILS IN REMARKS ON SECTION ON PAGE 3)

60. Are you a member, or do you intend to become a member of the armed forces, including the reserves? ☐ Yes ☐ No

61. Within the past five (5) years, has the Proposed Insured:

- **A.** Been charged with driving while impaired (alcohol, drugs, other) violation, had a driver's license revoked or suspended, or within the past twenty-four (24) months received three (3) or more moving violations? ☐ Yes ☐ No
- **B.** Flown as a pilot, student pilot, crew member, or flights in other than commercial aircraft? ☐ Yes ☐ No
- **C.** Engaged in scuba diving, parachuting, racing, or other hazardous sports or intend to do so? ☐ Yes ☐ No

62. Does the Proposed Insured intend to travel or reside outside the United States of America within the next twelve (12) months? ☐ Yes ☐ No

H - PROPOSED INSURED'S HEALTH INFORMATION (IF YES, PROVIDE DETAILS IN REMARKS SECTION ON PAGE 3)

63. Height: ____ feet _____ inches **64.** Weight: __________ **65.** Any weight loss or gain in the past twelve (12) months? ☐ Yes ☐ No

66. ______________________________
If #65 is Yes, How Much Weight? Loss or Gain? Reason For Change?

67. ______________________________ **68.** ______________
Name of Proposed Insured's Physician (First, MI, Last Name); if None, Write "None" Physician's Telephone Number

69. ______________________________
Physician's Street Address / City, State, Zip Code

70. ______________________________
Date Last Seen; Reason, Results of Visit

71. Has the Proposed Insured smoked or used tobacco in any form within the past twelve (12) months? ☐ Yes ☐ No
Type of Tobacco Used: ______________________ Last Use of Tobacco (MM/YYYY):______________

72. Has the Proposed Insured ever:

A. Used marijuana, cocaine, barbiturates, intravenous drugs, hallucinogens, sought advice, or treatment for alcohol or drug use? ☐ Yes ☐ No

B. Had any surgical operations? ☐ Yes ☐ No

C. Been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? ☐ Yes ☐ No

73. Has the Proposed Insured ever seen a physician, been diagnosed with, or treated for:

A. High blood pressure, coronary artery disease, or any other disorder or disease of the heart, blood vessels, or cardiovascular system, stroke, or any other disease of the cerebrovascular system? ☐ Yes ☐ No

B. Cancer, tumor, or any other growth, or malignancy? ☐ Yes ☐ No

C. Diabetes, thyroid disorder, anemia, hepatitis, or any other blood, or glandular disorder? ☐ Yes ☐ No

D. Any nose, throat, lung, or any other respiratory disorder, including sleep apnea? ☐ Yes ☐ No

E. Any disorder of the stomach, intestines, rectum, liver, or pancreas? ☐ Yes ☐ No

F. Any injury to, or disease of the bones, muscles, joints, eyes, or skin, including arthritis? ☐ Yes ☐ No

G. Epilepsy, seizures, brain disorder, or any other disease or disorder of the nervous system? ☐ Yes ☐ No

H. Anxiety, depression, or an emotional, behavior, mental, or nervous disorder? ☐ Yes ☐ No

I. Any disease or disorder of the kidney, bladder, or genital organs or system? ☐ Yes ☐ No

J. Any immune system disease or disorder including AIDS (Auto Immune Deficiency Syndrome) or positive HIV (Human Immunodeficiency Virus) test? ☐ Yes ☐ No

74. Other than as disclosed in the answers above, has the Proposed Insured within the past five (5) years:

A. Consulted, received treatment or advice from, been prescribed medication by any other physician or medical facility? If yes, state date reason, ordered by whom and reasons. ☐ Yes ☐ No

B. Had any abnormal diagnostic tests? ☐ Yes ☐ No

C. Been aware of any symptoms for which a physician has not been consulted? ☐ Yes ☐ No

D. Made claim for or received benefits, compensation, or a pension due to sickness or injury? ☐ Yes ☐ No

E. Had any known indication of any other physical disorder or abnormality? ☐ Yes ☐ No

I - PROPOSED INSURED'S FAMILY HISTORY

75. Has the Proposed Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer, stroke, or any other hereditary disease? ☐ Yes ☐ No *If yes, indicate family member, age at diagnosis, and disease.* ____________________________________

____

76. Proposed Insured's Family History

	Age, If Living	Cause Of Death	Age At Death
Father			
Mother			
Brothers: No. Living ________ No. Dead ________			
Sisters: No. Living ________ No. Dead ________			

REMARKS: Explain "Yes" answers to questions 60-62 and 71-74 below. If additional space is needed, attach a separate page that includes your printed name, signature and date at the bottom.

Question Number	Name, Address, & Phone Number of Physician, Medical Facility or Hospital Details (Dates, Reason, Diagnosis, Duration, Treatment and Test Results)

HOME OFFICE USE - DO NOT WRITE IN THIS SPACE **Endorsements & Amendments**

J - AGREEMENTS & SIGNATURES

1) I AGREE that the statements and answers contained in this application and in any medical examination required by the Union are complete and true to the best of my knowledge and belief. **2) I 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) I 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) I AGREE** that if I am not a member of the Union, this application serves as a membership application.

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

POLISH ROMAN CATHOLIC UNION OF AMERICA IS LICENSED TO DO BUSINESS IN YOUR STATE AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN THE STATE 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 (AGE 16 & UP)

______________________________ OWNER'S SIGNATURE, IF OTHER THAN PROPOSED INSURED

______________________________ APPLICANT'S SIGNATURE, IF OTHER THAN PROPOSED INSURED OR OWNER

______________________________ SALES REPRESENTATIVE'S SIGNATURE

______________________________ (PRINT) SALES REPRESENTATIVE'S NAME, CODE, AND DISTRICT

______________________________ SALES REPRESENTATIVE'S PHONE NUMBER AND EMAIL

____
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.

Notice to ______________________________ ______________________
PROPOSED INSURED'S SIGNATURE (AGE 16 & UP) DATE

BINDING PREMIUM RECEIPT, TEMPORARY INSURANCE AGREEMENT (TIA)

The insurance provided by this receipt, subject to the provisions of the policy applied for, will become effective as of the date the fully completed application and the first (1st) premium is paid in full. The coverage for which the application is made shall be in effect until the Company or the agent has notified the applicant in writing of declination or termination of insurance coverage or an offer to insure at higher than standard rates, and returned any unearned premium. Coverage is excluded if the proposed insured commits suicide, if the application contains material misrepresentation or is fraudulently completed or if a check or draft received in payment of the premium is not honored for payment when presented. Under no circumstances will the insurance provided by this receipt, including any insurance in force or applied for with this Company, or any benefit for accidental death, exceed $100,000 for each person proposed for coverage.

NO REPRESENTATIVE HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

Received $ _______________ from _______________________________________ on the Life of: ________________________________

in connection with an application for life insurance with the same date as this receipt. This payment is made and accepted subject to the above conditions.

POLISH ROMAN CATHOLIC UNION OF AMERICA

Chicago, Illinois

____ ________________________________

SALES REPRESENTATIVE'S SIGNATURE DATE

FRAUD WARNINGS

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Kansas Residents: 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 may be guilty of insurance fraud as determined by a court of law.

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

____ ____________________

PROPOSED INSURED'S NAME (FIRST, MI, LAST NAME) DATE OF BIRTH (MM/DD/YYYY)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past five (5) years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Polish Roman Catholic Union of America may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Polish Roman Catholic Union of America.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Polish Roman Catholic Union of America has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the recipient except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Polish Roman Catholic Union of America may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I agree that a photo static copy of this authorization shall be considered as effective and valid as the original. I know that I or my representative may request a copy of this authorization.

____ ____________________

SIGNATURE OF PROPOSED INSURED/PATIENT OR PERSONAL REPRESENTATIVE DATE (MM/DD/YYYY)

____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY OR RELATIONSHIP TO PATIENT

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