

PROPOSED INSURED'S HEALTH INFORMATION

43. _____ 44. _____
HEIGHT / WEIGHT DOCTOR'S NAME / STREET ADDRESS / TELEPHONE NUMBER

45. 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

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

47. Has Proposed Insured used any form of tobacco in the last 12 months? Yes No

If you answered "Yes" to questions 45-47, explain details below. Attach a separate page if additional space is needed.

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, 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. 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. This authorization is valid for 24 months after the date shown below. A photographic copy of this authorization shall be valid as the original. The purpose of the collected information is being used to underwrite and issue the policy. I know that I or my representative may request a copy of this authorization.

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. The applicant's representative is entitled to a copy of this form.

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