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 773-278-4595 • www.PRCUA.org

FINAL EXPENSE – LEVEL BENEFIT

LIFE INSURANCE APPLICATION

APPLICATION PART 1

PROPOSED INSURED'S INFORMATION

1. New Member: ☐ Yes ☐ No **2.** _____ 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.** _____ Date of Birth **8.** _____ Age **9.** _____ Birthplace (STATE / COUNTRY)

10. ☐ SSN ☐ TIN ☐ EIN # _____ **11.** _____
Occupation

12. _____
Email Address

13. _____
Telephone Number

14. _____
Proposed Insured's Driver's License Number / State Identification Number

15. _____ State Issued **16.** _____ Expiration Date

HOME OFFICE USE - DO NOT WRITE IN THIS SPACE

Endorsements & Amendments

OWNER'S INFORMATION (IF OTHER THAN PROPOSED INSURED)

17. _____ **18.** Sex: ☐ M ☐ F **19.** _____
Name (First, MI, Last Name) Date of Birth

20. _____ **21.** _____
Street Address / City, State, Zip Code Relationship to Proposed Insured

22. ☐ SSN ☐ TIN ☐ EIN # _____

23. _____ **24.** _____
Email Address Telephone Number

25. _____ **26.** _____ **27.** _____
Owner's Driver's License Number / State Identification Number State Issued Expiration Date

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

28. _____ **29.** Sex: ☐ M ☐ F **30.** _____
Name (First, MI, Last Name) Date of Birth

31. _____ **32.** _____
Street Address / City, State, Zip Code Relationship to Proposed Insured

33. ☐ SSN ☐ TIN ☐ EIN # _____

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

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

BENEFICIARY INFORMATION

39. PRIMARY (Name) _____ Relationship _____

☐ SSN ☐ TIN ☐ EIN # _____ Birth Date _____

40. CONTINGENT (Name) _____ Relationship _____

☐ SSN ☐ TIN ☐ EIN # _____ Birth Date _____

PLAN INFORMATION

41. Plan of Insurance (choose one):

a. ☐ Legacy Shield Immediate Benefit Final Expense (FEI) **-Full Face Amount - Plan 1**

42. Amount of Insurance: $_____

43. Premium $_____ **44.** Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

45. Electronic Premium (ACH/Credit Card): ☐ Yes ☐ No (If yes, complete appropriate payment form)

46. Do you elect to pay delinquent premiums pursuant to Automatic Premium Loan Provisions? ☐ Yes ☐ No

47. Billing Address: ☐ Insured ☐ Owner

___☐___ Check here if you are willing to accept any plan for which you qualify based on this application. The insurance for which you qualify may have a graded or return of premium death benefit for the first two (2) years, a face amount less than any indicated on this application.

ADDITIONAL LIFE INSURANCE INFORMATION

48. Does the Proposed Insured currently have any existing or pending life insurance? ☐ Yes ☐ No

49. Will this insurance replace in whole or in any part any other insurance or annuity? ☐ Yes ☐ No

50. If you answered "Yes" to questions 48 or 49, provide details below. Submit replacement form(s) if applicable.

COMPANY	CERTIFICATE #	FACE AMOUNT	ISSUE DATE
_____	_____	$_____	_____
_____	_____	$_____	_____

51. In the past 2 years, has the Proposed Insured had an application for life insurance postponed or declined? ☐ Yes ☐ No

If "Yes", provide details for the reason, since this may affect our decision: _____

_____

_____

SPECIAL REQUESTS:

52. Does the Proposed Insured have any existing annuity contracts or life insurance policies? ☐ Yes ☐ No

If yes, Company Name: _____

AGENT

53. Does the Proposed Insured have any existing annuity contracts or life insurance policies? ☐ Yes ☐ No

If yes, Company Name: _____

54. 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

PROPOSED INSURED'S HEALTH INFORMATION

SECTION A

55. Primary Care Physician's Name, Address and Telephone Number: (If none, state "none")

_____

_____

_____

56. Has Proposed Insured used any form of tobacco within the past 12 months? ☐ Yes ☐ No

If "Yes" type of tobacco used _____ Date of last use: _____

57. Proposed Insured: (If Height/Weight is outside our underwriting guidelines, Final Expense may not be available)

Height	Weight	Change in Past Year?	Reason for Weight Gain/Loss
_____	_____	_____ lbs. ☐ Gain ☐ Loss	_____

SECTION B

If all questions in Section B are answered "No", the Proposed Insured should apply for Legacy Shield Immediate Benefit Final Expense - Plan 1.

58. Is the Proposed Insured currently hospitalized, confined to a bed or nursing facility, confined to a wheelchair due to chronic illness or disease, or using oxygen equipment to assist in breathing, or receiving Hospice Care? ☐ Yes ☐ No

59. Has the Proposed Insured been medically advised to have an organ transplant, or been medically diagnosed as having metastatic cancer, Alzheimer's, dementia, mental incapacity, or been diagnosed, treated (including dialysis) or taken medication for renal insufficiency, kidney failure, liver failure, or respiratory failure? ☐ Yes ☐ No

60. Has the Proposed Insured been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

If any answer to questions 58 through 60 above is "Yes", the Proposed Insured should apply for Guaranteed Issue Final Expense (Modified Benefit) - Plan 3.

61. Has the Proposed Insured been medically diagnosed with diabetes combined with a medical history or any of the following: stroke, TIA, Heart disease, heart attack, coronary artery bypass, angioplasty, circulatory disease, or peripheral vascular disease? ☐ Yes ☐ No

62. Has the Proposed Insured taken insulin shots prior to age 35, have an A1C score above 8 or been treated for insulin shock or diabetic coma? ☐ Yes ☐ No

63. Within the past 2 years, has the Proposed Insured:

a) Been medically diagnosed or treated for angina (chest pain), stroke or TIA, cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? ☐ Yes ☐ No

b) Had a heart attack, aneurysm, heart valve surgery, coronary artery bypass surgery, angioplasty, or stent implant or had been medically advised to have surgery for brain or heart disease (including, but not limited to catheterization, a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? ☐ Yes ☐ No

c) Been medically diagnosed, treated, or taken medication for internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? ☐ Yes ☐ No

d) Had any diagnostic testing, surgery, or hospitalization recommended by a certified medical professional which has not been completed or for which the results have not been received? ☐ Yes ☐ No

e) Used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug use, or been convicted of any felony for driving under the influence of alcohol or drugs? ☐ Yes ☐ No

64. Has the Proposed Insured ever been medically diagnosed, treated, or taken medication for congestive heart failure, cardiomyopathy, Lou Gehrig's disease, or Huntington's disease, had an amputation caused by disease, or more than once occurrence of cancer (excluding basal or squamous cell skin cancer) in their lifetime? ☐ Yes ☐ No

65. Paralysis of two or more extremities or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? ☐ Yes ☐ No

If any answer to questions 61 through 65 above is "Yes", the Proposed Insured should apply for Legacy Shield Graded Benefit Final Expense - Plan 2.

REPRESENTATIONS - AUTHORIZATIONS

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.

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. **5) AGREE** that no agent has the authority to waive any answer or otherwise modify this application or to bind Polish Roman Catholic Union of America, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this application. **6) AGREE** that **$** _____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposits are accepted.

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.

ACKNOWLEDGE receipt of the following notices:

(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and

(b) MIB Pre-Notice

REPRESENTATIONS AND ACKNOWLEDGEMENTS:

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.

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.

SIGNATURES

SIGNED AT _____ THIS _____ DAY OF _____, 20_____

City / State — Day — Month — Year

_____ Proposed Insured's Signature

_____ Owner's Signature, if Other Than Proposed Insured

_____ Applicant's Signature, if Other Than Proposed Insured's or Owner

_____ Sales Representative's Signature

_____ Print Sales Representative's Name

_____ Code

_____ Sales Representative's Phone Number and Email

_____ Home Office Approval - HOME OFFICE USE ONLY

CONDITIONAL RECEIPT

TERMS AND CONDITIONS - Coverage issued bearing the date of this receipt will become effective on the date of the application, Coverage will be provided when the following conditions are met:

(1) The application and required information is received at our Home Office.
(2) All persons proposed for coverage are insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
(3) The full first premium is paid in cash on the date of application. The maximum amount of life insurance which will become effective under this receipt is either $25,000, or the face amount applied for, whichever is lower. This includes any previously pending insurance.

There will be no conditional insurance coverage and the Company's liability will be limited to returning any premium submitted to the Company with this Receipt if any of the following occurs: (A) one or more of the receipt's conditions have not been met exactly; (B) any Proposed Insured dies by suicide.

If the Policy is not issued exactly as applied for, it will become effective when it is accepted by the applicant and the first premium is paid. **The first premium must be paid upon approval**. If the application is declined or not approved within sixty days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

POLISH ROMAN CATHOLIC UNION OF AMERICA
Chicago, Illinois

LIFE PLAN _____ **Amount $** _____

ALL PREMIUM PAYMENTS MUST BE PAYABLE TO THE POLISH ROMAN CATHOLIC UNION OF AMERICA (PRCUA). DO NOT MAKE PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

By _____ _____, 20_____
SALES REPRESENTATIVE'S SIGNATURE DATE

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.

APPLICATION PART 4

AGENT'S REPORT

1. Agent Checklist

A. Did you give the applicant a copy of the Privacy Notice and other disclosure information?	☐ Yes	☐ No
B. Are you related to the Proposed Insured? If "Yes", provide details below.	☐ Yes	☐ No
C. Was this application taken in person? If "No", provide details below.	☐ Yes	☐ No
D. Do you know anything not disclosed which might affect the underwriting of this risk? If "Yes", provide details below.	☐ Yes	☐ No
E. Is there another application currently pending or being submitted to any other life insurance company? If "Yes", provide details below.	☐ Yes	☐ No
F. Has any Proposed Insured applied elsewhere for any insurance coverage within the past 6 months? If "Yes", provide details below.	☐ Yes	☐ No
G. Is replacement of existing insurance involved in this application? If "Yes", provide details below.	☐ Yes	☐ No
a. If yes: Have you submitted the appropriate replacement forms?	☐ Yes	☐ No

If you answered "**Yes**" to questions **B**, **D**, **E**, **F** or **G** or "**No**" to question **C** above, provide full details: _____

_____

_____

_____

_____

_____

_____

2. Remarks:

_____

_____

_____

_____

I certify I have accurately recorded all information given by the Proposed Insured and my statement on this Agent's Report are correct to the best of my knowledge. I claim full credit for this application unless other instructions are given below.

_____
DATE

_____
SALES REPRESENTATIVE'S NAME

_____
SALES REPRESENTATIVE'S SIGNATURE

_____
SALES REPRESENTATIVE'S CODE

_____
SALES REPRESENTATIVE'S PHONE NUMBER AND EMAIL

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*