PRCUALife

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.** _____ Society

_____ Certificate - HOME OFFICE USE

_____ ☐ Medical Required 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 INSURED 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. 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

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

E - ADDITIONAL LIFE INSURANCE INFORMATION

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

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

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

53. 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	ACCIDENTAL DEATH BENEFIT	REPLACING?	1035 EXCHANGE?
_____	_____	$_____	_____	$_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	$_____	_____	$_____	☐ Yes ☐ No	☐ Yes ☐ No

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

AGENT

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

56. 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

57. 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 _____

58. 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 SECTION ON PAGE 3)

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

60. 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 been convicted of 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 intend to do so? ☐ Yes ☐ No

61. 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)

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

65. _____
IF #64 IS YES, HOW MUCH WEIGHT? LOSS OR GAIN? REASON FOR CHANGE?

66. _____ **67.** _____
NAME OF PROPOSED INSURED'S PHYSICIAN (FIRST, MI, LAST NAME); IF NONE, WRITE "NONE" PHYSICIAN'S TELEPHONE NUMBER

68. _____
PHYSICIAN'S STREET ADDRESS / CITY, STATE, ZIP CODE

69. _____
DATE LAST SEEN; REASON, RESULTS OF VISIT

70. 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): _____

71. 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, diagnosis, or treatment? ☐ Yes ☐ No

72. Has the Proposed Insured ever seen a physician, been diagnosed by a licensed member of the medical profession 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? ☐ Yes ☐ No

73. Has the Proposed Insured ever been diagnosed or treated for AIDS (Auto Immune Deficiency Syndrome) and/or HIV (Human Immunodeficiency Virus) infection by a licensed member of the medical profession? ☐ 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, excluding HIV? ☐ Yes ☐ No
- **C.** Made claim for or received benefits, compensation, or a pension due to sickness or injury? ☐ Yes ☐ No
- **D.** 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, or stroke? ☐ 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 _____			
Sisters: No. Living _____			

REMARKS: Explain "Yes" answers to questions 59-61 and 70-74 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 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. **4) I AGREE** that if I am not a member of the Union, this application serves as a membership application.

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 DATE 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

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO CERTIFICATE DELIVERY UNLESS AND UNTIL ALL CONDITIONS ON THIS RECEIPT ARE MET. If: (1) an amount equal to at least one month premium, for the plan and amount applied for, is submitted; (2) all underwriting requirements, including any medical examinations required by the rules of the Union are completed; and (3) the Proposed Insured is, on the date indicated on this receipt, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the rules and practices of the Union. THEN insurance under the certificate applied for shall become effective on the latest of (a) the register date of application, (b) the date of the last of any medical examinations, and (c) any date of issue requested in the application.

THE AMOUNT OF INSURANCE WHICH MAY BECOME EFFECTIVE PRIOR TO CERTIFICATE DELIVERY SHALL NOT EXCEED $100,000, which amount includes any additional benefits for death by accident. If any of the above conditions is not met, the liability of the PRCUA shall be limited to the return of the amount submitted.

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."

Some states require us to provide the following information to you:

New York 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 30 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, except to the extent that any health care provider has acted in reliance upon this Authorization prior to notice of revocation, 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 _____

POLISH ROMAN CATHOLIC UNION OF AMERICA 984 N Milwaukee Ave • Chicago IL • 60642-4101

NEW YORK LIFE AND ANNUITY SUITABILITY QUESTIONNAIRE

Instructions:

PRCUA*Life* is required by your state insurance department to ask for information that will help determine whether a life or annuity contract is suitable for your investment goals and financial situation. The questions pertain to your personal situation at the time of this application and to your understanding of the features of the product for which you are applying. This information will not be used for any other purpose and will remain confidential.

If you have any questions, or for additional information, please contact us at ☎ 1-800-772-8632, or visit our website at www.prcua.org.

I understand that should I decline to provide the requested information, or should I provide inaccurate information, I am limiting the protection afforded me by the New York statutes regarding the suitability of this purchase.

☐ **I have chosen NOT to provide this information at this time.**

☐ **I have chosen to provide LIMITED information at this time.**

1. PROPOSED INSURED/ANNUITANT'S PERSONAL INFORMATION

Name (Last Name, First Name, Middle Initial)

Date Of Birth (MM/DD/YYYY) | Age | Sex | Tax Status

Number And Age Of Dependents

2. APPLICANT/OWNER OTHER THAN PROPOSED INSURED/ANNUITANT

Owner's Name (Last Name, First Name, Middle Initial)

Date Of Birth (MM/DD/YYYY) | Age | Sex

Entity

Tax Status | Relationship To Insured(s)/Annuitant(s)

Form Of Ownership

Supporting Documents (List)

	PROPOSED INSURED/ANNUITANT	OWNER/JOINT OWNER
Annual Income:		
Source of Income:		
Annual Household Income:		
Net Worth:		
Liquid Assets:		
Do you currently own any annuities?	☐ Yes ☐ No	☐ Yes ☐ No
Please list:		
Do you currently own life insurance?	☐ Yes ☐ No	☐ Yes ☐ No
Please list:		

Proposed Insured/Annuitant Signature | Date | Owner/Joint Owner Signature | Date

	PROPOSED INSURED/ANNUITANT	OWNER/JOINT OWNER
Does your income cover all of your living expenses, including medical?	☐ Yes ☐ No	☐ Yes ☐ No
Explain:		
Do you expect changes to your living expenses?	☐ Yes ☐ No	☐ Yes ☐ No
Explain:		
Do you anticipate changes in your out-of-pocket medical expenses?	☐ Yes ☐ No	☐ Yes ☐ No
Explain:		
Is your income sufficient to cover future changes in your living and/or out-of-pocket medical expenses during the surrender charge period?	☐ Yes ☐ No	☐ Yes ☐ No
If no, please explain:		
Do you have an emergency fund for unexpected expenses?	☐ Yes ☐ No	☐ Yes ☐ No
Explain:		

Why are you purchasing this life or annuity certificate? _____

_____

What are your investment objectives? (Check all that apply)

☐ Income ☐ Growth (long term) ☐ Safety of Principal & Income

☐ Safety of Principal & Growth ☐ Pass assets to a beneficiary or beneficiaries at death

☐ Other: _____

Describe your risk tolerance: (Check all that apply)

☐ Conservative ☐ Moderately Conservative ☐ Moderate

☐ Moderately Aggressive ☐ Aggressive ☐ Other: _____

Comments: _____

Describe your investment experience by type & length of time: _____

What is the source of the funds for the purchase of the proposed life or annuity certificate? _____

How long do you plan to keep the proposed life or annuity certificate? _____

Will the proposed life or annuity certificate replace another product? ☐ Yes ☐ No

If yes, will you pay a penalty or other charge to obtain these funds? ☐ Yes ☐ No

If yes, what is the amount of the charge or penalty? _____

_____ _____ _____ _____

PROPOSED INSURED/ANNUITANT SIGNATURE DATE OWNER/JOINT OWNER SIGNATURE DATE

3. AGENT INFORMATION

NOTE:

This section, which includes three questions and option A or B, is to be completed by the Agent or Managing General Agent proposing purchase. I hereby attest to the information on behalf of myself and all financial representatives who participated in making a recommendation regarding the transaction relating to this questionnaire.

Advantages of purchasing the proposed life or annuity certificate:

_____

_____

Disadvantages of purchasing the proposed life or annuity certificate:

_____

_____

The basis for my recommendation to purchase the proposed life or annuity certificate or to replace/exchange your existing life or annuity certificate(s):

_____

_____

☐ **Option A -** The proposed life or annuity certificate purchased related to this questionnaire was recommended by me to the proposed insured/annuitant and:

1. I have collected the proposed insured/annuitant's suitability information as required under Regulation 187;
2. My recommendation to the proposed insured/annuitant is based on my evaluation of the relevant suitability information provided by the proposed insured/annuitant;
3. My recommendation reflects the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use under the circumstances then prevailing;
4. In my professional opinion: a) the proposed life or annuity certificate is suitable for the proposed insured/annuitant, based on their suitability information provided to me; b) the proposed insured/annuitant would benefit from certain features of the certificate being applied for; and c) the proposed insured/annuitant has the financial ability to meet the financial commitments under the certificate;
5. I have reasonably informed the proposed insured/annuitant of various features of the certificate and potential consequences of the proposed life or annuity certificate, both favorable and unfavorable;
6. I have disclosed to the proposed insured/annuitant and will maintain documentation on file: a) the manner in which I would be compensated for the proposed life or annuity certificate and for servicing of the certificate; b) in a reasonable summary format, all relevant suitability considerations and product information, both favorable and unfavorable, that provide the basis for my recommendation; and c) the basis for my recommendation of the proposed life or annuity certificate, if applicable, and the facts and analysis to support that recommendation; and
7. Only the interests of the proposed insured/annuitant were considered in making the recommendation and I have adequate knowledge to make the recommendation.

☐ **Option B** - The proposed life or annuity certificate purchased related to this questionnaire was not recommended by me to the proposed insured/annuitant due to: *(please choose one)*

- ☐ I made reasonable efforts to collect the required suitability information from the proposed insured/annuitant, but they refused to provide it and I have not made any recommendations;
- ☐ I did not make a recommendation in connection with the proposed life or annuity certificate related to this questionnaire;
- ☐ The proposed insured/annuitant wishes to enter into the proposed life or annuity certificate related to this questionnaire even though I do not recommend it.

To the best of my knowledge and belief, the information in this questionnaire is true and complete:

_____ _____

AGENT'S SIGNATURE DATE SIGNED

NOTE:

No questions or response areas are to be left blank when offered to the Proposed Insured/Annuitant and/or Applicant for signature. If any information requested is unavailable, not applicable or unknown, the insurance agent must indicate that.

4. ACKNOWLEDGEMENTS AND SIGNATURES

OWNER:

DO NOT SIGN THIS FORM IF ANY ITEM HAS BEEN LEFT BLANK, BEFORE CAREFULLY REVIEWING THE INFORMATION RECORDED, OR IF ANY OF THE INFORMATION RECORDED IS NOT TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE.

THE APPLICANT, JOINT APPLICANT AND/OR OWNER MAY SUBSTITUTE THEIR SIGNATURES FOR INITIALS ON ALL FORM PAGES WITH THE EXCEPTION OF THE SIGNATURES BELOW, WHICH ARE REQUIRED.

PROPOSED INSURED/ANNUITANT SIGNATURE _____ DATE SIGNED _____

OWNER/JOINT OWNER SIGNATURE _____ DATE SIGNED _____

5. EXPLANATION OF TERMS

"Age" is the natural person's attained age on the day the form is completed.

"Tax Status" is the Consumer's Federal Income Tax filing status such as "single" or "married filing jointly"; if "Exempt", so state.

"Form of Ownership" is the type of entity, other than a natural person, including a corporation, trust, partnership, limited liability company, or other business or not-for-profit entity.

"Supporting documents" are the documents that provide a basis for the relationship between the Proposed Insured/Annuitant, Joint Owner, if applicable, and the Applicant/Owner as it may exist.

"Annual Income" is income received during a calendar year, whether earned or unearned.

"Source of annual income" is the income-generating source, such as pension income, dividends, or earned income, etc.

"Annual household income" is the combined annual income received by all household members each calendar year.

"Total Net Worth" is the Consumer's total assets minus total liabilities or encumbrances applicable to those assets.

"Liquid Assets" are financial holdings that can readily be converted into their cash equivalent, without loss of principal.

"Investment Objectives" are the Consumer's stated goals as described to the insurance agent. These may include, but are not limited to the following: (1) Income, (2) Growth (long term capital appreciation), (3) Safety of Principal and Income, (4) Safety of Principal and Growth, (5) To pass the investment to a beneficiary or beneficiaries at death.

"Risk Tolerance" means the degree of uncertainty that an investor can reasonably tolerate with regard to a negative change in his or her investments. Examples of risk tolerance levels may include the following: (1) Conservative (prefer little or no risk), (2) Moderately Conservative (some risk, reduced safety of principal), (3) Moderate (average risk with potential losses, risk of principal and potentially higher returns), (5) Aggressive (wiling to sustain losses or loss of principal in pursuit of higher returns).

"Source of the funds" to be used to purchase the proposed life or annuity certificate means from where the funds will come to purchase the life or annuity certificate, and may include, but are not limited to: (1) An existing annuity or life insurance contract, (2) Liquid Assets, including, but not limited to: cash in banks, maturing certificates of deposit, and money market accounts, (3) Personal Loans, (4) Equity Loans, (5) Mortgages, Reverse Mortgages, (6) Death Benefit Proceeds, (7) Funds received upon retirement from employment, including, but not limited to: 401(k) accounts, pensions, and other tax-sheltered funds, (8) Equities, mutual funds, or bonds, (9) Proceeds from real estate transactions.

"Intended use of the life or annuity" means the purpose for which the Consumer is considering the recommended purchase or exchange. This may include the following: (1) Immediate income (within 60 days or less), (2) Tax Shelter (protection from taxation of all types while in force), (3) Interest earnings, (4) Income stream at a stated age, (5) Creditor Protection (a desire to protect assets from attachment by any legal process), (6) Other, as stated by the Consumer.

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

POLISH ROMAN CATHOLIC UNION OF AMERICA 984 N Milwaukee Ave • Chicago IL • 60642-4101

AGENT'S REQUEST FOR DISCLOSURE STATEMENT – LIFE TO LIFE REPLACEMENT ONLY

IMPORTANT - IT MAY NOT BE IN YOUR BEST INTEREST TO SURRENDER, LAPSE, CHANGE OR BORROW FROM EXISTING LIFE INSURANCE POLICIES IN CONNECTION WITH THE PURCHASE OF A NEW LIFE INSURANCE POLICY WHETHER ISSUED BY THE SAME OR A DIFFERENT INSURANCE COMPANY. YOU ARE URGED TO CONTACT YOUR EXISTING AGENT OR INSURANCE COMPANY PRIOR TO COMPLETING THE TRANSACTION. THEY CAN HELP YOU DECIDE WHETHER THE REPLACEMENT IS IN YOUR BEST INTEREST.

NAME OF OWNER _____ TELEPHONE _____

ADDRESS / CITY / STATE / ZIP _____

EXISTING INSURER'S NAME _____ EXISTING CERTIFICATE / POLICY NUMBER _____

EXISTING INSURER'S ADDRESS / CITY / STATE / ZIP _____

EXISTING INSURER'S TELEPHONE _____ EXISTING INSURER'S FAX NUMBER _____

NAME OF AGENT _____ TELEPHONE _____

PROPOSED PRODUCT TYPE _____

I have personally completed this form and certify that it is correct to the best of my knowledge and ability.

☒ _____ _____

SIGNATURE OF AGENT DATE

I may replace the above policy with a new Life Insurance. Please accept this signed form as my authorization for you to release the information necessary to complete the required Disclosure Statement for the above-referenced policy. By signing below, the contract owner(s) authorize(s) and request(s) the above named replacing agent and company to obtain account information from the current insurer related to the existing life policy.

☒ _____ _____

SIGNATURE OF OWNER DATE

☒ _____ _____

SIGNATURE OF OWNER DATE

POLISH ROMAN CATHOLIC UNION OF AMERICA
984 N Milwaukee Ave • Chicago IL • 60642-4101

DISCLOSURE STATEMENT
LIFE TO LIFE REPLACEMENT ONLY

IMPORTANT - IT MAY NOT BE IN YOUR BEST INTEREST TO SURRENDER, LAPSE, CHANGE OR BORROW FROM EXISTING LIFE INSURANCE POLICIES IN CONNECTION WITH THE PURCHASE OF A NEW LIFE INSURANCE POLICY WHETHER ISSUED BY THE SAME OR A DIFFERENT INSURANCE COMPANY. YOU ARE URGED TO CONTACT YOUR EXISTING AGENT OR INSURANCE COMPANY PRIOR TO COMPLETING THE TRANSACTION. THEY CAN HELP YOU DECIDE WHETHER THE REPLACEMENT IS IN YOUR BEST INTEREST.

FOR YOUR PROTECTION, the Insurance Department of the State of New York requires that you be given this Disclosure, the IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies and the Definition or Replacement, together with policy information on all proposed and existing coverage affected.

NAME OF APPLICANT _____ TELEPHONE _____

ADDRESS / CITY / STATE / ZIP _____

NAME OF AGENT _____ TELEPHONE _____

COMPANY _____ ADDRESS / CITY / STATE / ZIP _____

The information on existing coverage on this form was obtained from:

☐ The replaced company ☐ Approximations if replaced company failed to provide information in the prescribed time

1. DESCRIPTION OF TRANSACTION: AS OF DATE:

Proposed Policy		Existing Policies Affected (1)	(2)	(3)
	Company			
	Customer Service Telephone Number			
	Type of Insurance			
	Face Amount			
	Rider _____			
	Rider _____			
	Rider _____			
	Rider _____			
	Rider _____			
	Premium			
	Contract Number	#	#	#
	Issue Date			

(continued on page 2)

_____	Surrender Charge	_____	_____	_____
_____%	Guaranteed Interest Rate	_____%	_____%	_____%
_____%	Loan Interest Rate	_____%	_____%	_____%
_____ Years	Contestable Expiry Date	_____Mo/Yr	_____Mo/Yr	_____Mo/Yr
_____ Years	Suicide Expiry Date	_____Mo/Yr	_____Mo/Yr	_____Mo/Yr

Existing coverage to be changed by:

Lapse or Surrender	☐	☐	☐
Amendment or Reissue	☐	☐	☐
Loan or Withdrawal	☐	☐	☐
Reduction to	_____	_____	_____
Reduced Paid-Up For	_____	_____	_____
Extended Term For	_____Yrs_____Mos	_____Yrs_____Mos	_____Yrs_____Mos

Cash released by change	Year_____	_____	_____	_____
	Year_____	_____	_____	_____
	Year_____	_____	_____	_____

Use of cash released: _____

2. SUMMARY RESULT COMPARISON:

New With Existing Coverage Changed			Existing Coverage Unchanged	
Guaranteed	Non-Guaranteed	**Annual Premium**	Guaranteed	Non-Guaranteed
_____	_____	At Present	_____	_____
_____	_____	5 Years Hence	_____	_____
_____	_____	10 Years Hence	_____	_____
Guaranteed	Non-Guaranteed	**Surrender Value**	Guaranteed	Non-Guaranteed
_____	_____	At Present	_____	_____
_____	_____	5 Years Hence	_____	_____
_____	_____	10 Years Hence	_____	_____
Guaranteed	Non-Guaranteed	**Death Benefit**	Guaranteed	Non-Guaranteed
_____	_____	At Present	_____	_____
_____	_____	5 Years Hence	_____	_____
_____	_____	10 Years Hence	_____	_____
Guaranteed	Non-Guaranteed	**Dividends**	Guaranteed	Non-Guaranteed
_____	_____	At Present	_____	_____
_____	_____	5 Years Hence	_____	_____
_____	_____	10 Years Hence	_____	_____

AGENT'S STATEMENT:

1. The primary reason(s) for recommending the new life insurance policy is (are):

_____

_____

2. The existing life insurance policy cannot meet the applicant's objective because:

_____

_____

3. The advantages of continuing the existing life insurance policy without changes are:

_____

_____

REMARKS:

_____

_____

_____

☐ The attached proposal, including sales material, was used in this sale.

☐ No proposal or sales material was used in this sale.

If more than three existing life insurance policies are to be affected by this transaction or if more than one life insurance policy is proposed, the first page of this Disclosure Statement must be completed for such additional life insurance policies. In addition, a composite comparison shall be completed for all existing life insurance policies to all proposed life insurance policies. The proposal, including sales material used in the sale of the proposed life insurance policy, must accompany the submission of this form to the insurer. Copies must be given to the applicant.

I have personally completed this form and certify that it is correct to the best of my knowledge and ability.

☒ _____ _____

SIGNATURE OF AGENT DATE

I hereby acknowledge that I received and read the above "Disclosure Statement" before I signed the application for new coverage. By signing below, the contract owner(s) authorize(s) and request(s) the above named replacing agent and company to obtain account information from the current insurer related to the existing life insurance policy.

☒ _____ _____

SIGNATURE OF OWNER DATE

☒ _____ _____

SIGNATURE OF OWNER DATE

IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS

THIS NOICE IS FOR YOUR BENEFIT AND REQUIRED BY REGULATION NO.60

You are contemplating the purchase of a Life Insurance Policy or Annuity Contract in connection with the surrender, lapse or change of an existing Life Insurance or Annuity Contracts. The agent is required to give you this notice together with a signed Disclosure Statement containing the Summary Result Comparison for the new Life Insurance Policy or Annuity Contract and any Life Insurance Policy or Annuity Contracts to be changed that sets forth the facts of the transaction and its advantages and disadvantages to you. Your decision could be a good one – or a mistake – so make sure you understand the facts. You should:

1. Carefully study the Disclosure Statement, which includes a Summary Result Comparison, until you are sure you understand fully the effect of the transaction.
2. Ask the company or agent from whom you bought your existing Life Insurance or Annuity Contracts to review with you the transaction and the Disclosure Statement. You may be able to effect the changes you desire more advantageously with them. Their customer service telephone number is contained in the Disclosure Statement.
3. Consult your tax advisor. There may be unfavorable tax implications associated with the contemplated changes to your existing Life Insurance or Annuity Contracts.

As a general rule, it is often not advantageous to drop or change existing coverage in favor of new coverage, whether issued by the same or a different insurance company. Some of the reasons it may be disadvantageous are:

1. The amount of the annual premium under an existing life insurance policy may be lower than that called for by a new life insurance policy having the same or similar benefits. Any replacement of the same type of policy will normally be at a higher premium rate based upon the insured's then attained age.
2. Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provision for surrender changes, therefore are placement involving annuity contracts may result in the imposition of surrender charges.
3. The incontestable and suicide clauses begin anew in a new life insurance policy. This could result in a claim being denied under the new life insurance policy that would have been paid under the life insurance policy that was replaced.
4. An existing life insurance policy or annuity contract often has more favorable provisions than a new life insurance policy or annuity contract in areas such as loan interest rate, settlement options, disability benefits and tax treatment.
5. There have been changes in your health since the purchase of the existing coverage.
6. The insurance company with which you have existing coverage can often make a desired change on terms that would be more favorable than if you replaced existing coverage with new coverage.

You have the right, within sixty (60) days from the date of delivery of a new Insurance Policy or Annuity Contract, to return it to insurer and receive an unconditional full refund of all premiums or considerations paid on it, or in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender benefits provided under the policy or contract, plus the amount of all fees and other charges deducted from gross considerations or imposed under the Life Insurance Policy or Annuity Contract, and may have the right to reinstate or restore any Life Insurance Policies and Annuity Contracts that were surrendered, lapsed, or changed in the transaction of their former status to the extent possible and in accordance with the insurer's published reinstatement rules to the extent such rules are not inconsistent with the provisions of this part.

Important: This right should not be viewed as reinstating or restoring your Life Insurance Policy or Annuity Contract to the same condition as if it had never been replaced. There may be consequences in reinstating or restoring your Life Insurance Policy or Annuity Contract, including but not limited to:

- The right to reinstate or restore your Life Insurance Policy or Annuity Contract applies only to companies subject to New York Insurance Laws
- Your Life Insurance Policy or Annuity Contract is subject to your specific company's reinstatement rules, which may vary from company to company. These rules may require payment of both premiums and interest; however, you will not be subject to Evidence of Insurability, or a new Contestable or Suicide Period;
- You may not receive the interest or investment performance during the period the Life Insurance or Annuity Contract was replaced; and
- There may be unfavorable Federal Income Tax consequences as a result of the reinstatement of your Life Insurance Policy or Annuity Contract.

Important: In the case of a Variable or Market Value Adjustment Policy or Contract, the value of the Policy or Contract may increase or decrease during the sixty (60) day period depending on the performance of the underlying investments, which may affect the value of the refund you receive.

I HEREBY ACKNOWLEDGE THAT I READ THE ABOVE "IMPORTANT NOTICE" AND HAVE RECEIVED A COPY OF SAME.

☒ _____ _____

SIGNATURE OF OWNER DATE

☒ _____ _____

SIGNATURE OF OWNER DATE

POLISH ROMAN CATHOLIC UNION OF AMERICA
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DEFINITION OF REPLACEMENT

In order to determine whether you are replacing or otherwise changing the status of existing Life Insurance Policies or Annuity Contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new Life Insurance Policy or a new Annuity Contract, has existing coverage been or is it likely to be:

1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the Life Insurance Policy or Annuity Contract, or otherwise terminated?
☐ Yes ☐ No

2) Changed or modified into Paid-Up Insurance; continued as Extended Term Insurance or under another form of non-forfeiture benefit; or otherwise reduced in value by the use of non-forfeiture benefit divided accumulations, dividend cash values or other cash values?
☐ Yes ☐ No

3) Changed or modified so as to effect a reduction either in the amount of the existing Life Insurance or Annuity benefit or in the period of time the existing Life Insurance or Annuity benefit will continue in force?
☐ Yes ☐ No

4) Reissue with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies?
☐ Yes ☐ No

5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies?
☐ Yes ☐ No

6) Continued with a stoppage of premium payments or reduction in the amount of premium paid?
☐ Yes ☐ No

If you have answered "Yes" to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and your agent is required to provide you with a complete Disclosure Statement and the Important Notice regarding replacement or change of Life Insurance Policies or Annuity Contracts.

☒ _____ _____
SIGNATURE OF OWNER DATE

☒ _____ _____
SIGNATURE OF OWNER DATE

To the best of my knowledge, a replacement is involved in this transaction:
☐ Yes ☐ No

☒ _____ _____
SIGNATURE OF AGENT DATE