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

68. _____
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, been medically treated for or been medically advised to have treatment or received counseling for alcoholism, addiction, drug use, dependency or abuse? ☐ 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), ARC (AIDS Related Complex) 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. 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 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)

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.

Fraud Warning: 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 subjects such person to criminal and civil penalties.

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

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

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

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PROPOSED INSURED'S 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 36 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.

☒ _____ _____

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