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

EXPRESS LIFE APPLICATION

PROPOSED INSURED'S INFORMATION

☐ Adult ☐ Juvenile **1.** _____ Society _____ Certificate - HOME OFFICE USE _____ Roster - HOME OFFICE USE

2. _____ Name (First, MI, Last Name)

3. _____ Street Address / City, State, Zip Code

4. Sex: ☐ Male ☐ Female **5.** _____ Date of Birth **6.** _____ Age

7. ☐ SSN ☐ TIN ☐ EIN # _____ **8.** _____ Occupation

9. _____ Email Address **10.** _____ Telephone Number

11. _____ Proposed Insured's Driver's License Number / State Identification Number **12.** _____ State Issued **13.** _____ Expiration Date

OWNER'S INFORMATION (IF OTHER THAN PROPOSED INSURED)

14. _____ Name (First, MI, Last Name) **15.** _____ Relationship to Proposed Insured

16. ☐ SSN ☐ TIN ☐ EIN # _____

17. _____ Email Address **18.** _____ Telephone Number

PLAN INFORMATION

19. _____ Plan of Insurance **20.** _____ Amount of Insurance

21. Premium $_____ **22.** Mode: ☐ Single ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

23. Riders*: ☐ GIO ☐ ADB ☐ WP ☐ JPB *Not all riders are available with all plans **24.** ☐ ACH (complete form ACH1)

25. In the event of 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

26. Is this insurance intended to replace any now in force? ☐ Yes ☐ No **27.** Is Proposed Insured a PRCUA Member? ☐ Yes ☐ No

28. Dividend Election (choose one): ☐ Paid in Cash ☐ Purchase Paid-Up Additions

BENEFICIARY INFORMATION

29. PRIMARY (Name) _____

☐ SSN ☐ TIN ☐ EIN # _____ Relationship _____

30. CONTINGENT (Name) _____

☐ SSN ☐ TIN ☐ EIN # _____ Relationship _____

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

31. _____ Name (First, MI, Last Name) **32.** Sex: ☐ Male ☐ Female

33. _____ Street Address / City, State, Zip Code **34.** _____ Relationship to Proposed Insured

35. _____ Email Address **36.** _____ Telephone Number

37. _____ Applicant's Driver's License Number / State Identification Number **38.** _____ State Issued **39.** _____ Expiration Date

PROPOSED INSURED'S HEALTH INFORMATION

40. _____ Height / Weight **41.** _____ Doctor's Name / Street Address / Telephone Number

42. 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

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

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

PROPOSED INSURED'S HEALTH INFORMATION

(continued from page 1)

If you answered "Yes" to questions **42**-**44** on page 1, explain details below. Attach a separate page if additional space is needed.

Date	Name & Address of Physician & Hospital	Specific Reason & Results

AGREEMENT - AUTHORIZATION - ACKNOWKEDGMENT - 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.

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 presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

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.

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