



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. _____ 8. _____ 9. _____
DATE OF BIRTH AGE BIRTHPLACE (STATE / COUNTRY)

10. SSN TIN EIN # _____ 11. _____
OCCUPATION

12. _____ 13. _____
EMAIL ADDRESS TELEPHONE NUMBER

14. _____ 15. _____ 16. _____
PROPOSED INSURED'S DRIVER'S LICENSE NUMBER / STATE IDENTIFICATION NUMBER STATE ISSUED 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
 - b. Legacy Shield Graded Benefit Final Expense (FEG) -Percentage of Face Amount First Two (2) Years - Plan 2
 - c. Guaranteed Issue Final Expense (Modified Benefit) (GIWL) -Return of Premium + 10% First Two (2) Years - Plan 3
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. Do you, the Applicant, have any existing annuity contracts or insurance policies? Yes No
- If yes, Company Name: _____
- AGENT**
53. Does the Applicant 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. <input type="checkbox"/> Gain <input type="checkbox"/> 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 or 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 one 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 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.

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 CHECKS MUST BE PAYABLE TO THE POLISH ROMAN CATHOLIC UNION OF AMERICA (PRCUA). DO NOT MAKE CHECK 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.

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

Third Party Designee(s) ("Designee")

You may name a Third Party Designee(s) ("Designee") to provide extra security against the unintentional lapse of your insurance policy. This will enable us to send a notification to the person you name in case of an unpaid premium. If you already have a Designee listed with us, you may use this form to change the Designee, add an additional Designee, or provide current contact information for the Designee. If your premiums are paid by automatic bank withdrawal, providing a Designee may be helpful in case the request for the withdrawal is returned for some reason. Please note that this is not notice of a lapse in your coverage, just an opportunity to offer you extra protection against an unintentional lapse in the future. If you do not wish to take advantage of this opportunity, please sign the waiver below and return the form to us using the enclosed postage paid envelope.

If you would like to add or change a Designee, please complete the information in the space provided and sign below. You have the right to change this written designation at least once every two years. If you elect to change or add, only the individuals below will be listed as an advisor on your policy.

1. Designee's Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____

2. Second Designee's Name (optional): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____

Signature _____ Date _____

If you do not wish to name a designee above, please check the box and sign below:

WAIVER OF PROTECTION AGAINST UNINTENDED LAPSE:

I elect NOT to designate any person to receive such notice. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Signature _____ Date _____

