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

SIMPLIFIED ISSUE FINAL EXPENSE GRADED BENEFIT LIFE INSURANCE APPLICATION

APPLICATION PART 1

PROPOSED INSURED'S INFORMATION

1. New Member: ☐ Yes ☐ No **2.** _____ Society

_____ Certificate - HOME OFFICE USE

_____ Roster - HOME OFFICE USE

3. _____ Name (First, MI, Last Name) **4.** Sex: ☐ M ☐ F

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

6. Marital Status: ☐ Single ☐ Married ☐ Widowed **7.** _____ Date of Birth **8.** _____ Age **9.** _____ Birthplace (State / Country)

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

12. _____ Email Address **13.** _____ Telephone Number

14. _____ Proposed Insured's Driver's License Number / State Identification Number **15.** _____ State Issued **16.** _____ Expiration Date

HOME OFFICE USE - DO NOT WRITE IN THIS SPACE

Endorsements & Amendments

OWNER'S INFORMATION (IF OTHER THAN PROPOSED INSURED)

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

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

22. ☐ SSN ☐ TIN ☐ EIN # _____

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

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

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

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

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

33. ☐ SSN ☐ TIN ☐ EIN # _____

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

36. _____ Applicant's Driver's License Number / State Identification Number **37.** _____ State Issued **38.** _____ 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. ☐ Level Pay Final Expense (FE)*** If you answer "YES" to any question in Part 2 Section B, you ARE NOT ELIGIBLE for FINAL EXPENSE.**

b. ☐ (FE) 5-Pay

c. ☐ (FE) Single Pay

d. ☐ Graded Benefit Whole Life (GBWL)*** If applying only for GBWL, do not complete Application Part 2.**

42. Amount of Insurance: $_____

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

45. Electronic Premium (ACH): ☐ Yes ☐ No (If yes, complete form ACH1)

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

47. Billing Address: ☐ Insured ☐ Owner

48. (GBWL Only) Do you understand that a reduced death benefit may be payable during the first two certificate years according to the terms of the certificate? ☐ Yes ☐ No

ADDITIONAL LIFE INSURANCE INFORMATION

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

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

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

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

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

If "Yes", provide details here: _____

_____

_____

SPECIAL REQUESTS:

PROPOSED INSURED'S HEALTH INFORMATION

SECTION A

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

_____

_____

_____

54. 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: _____

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

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

SECTION B

Please check "Yes" or "No" beside each question below. If you answer "YES" to questions 58 through 67, you ARE NOT ELIGIBLE for Final Expense.

56. Do you wish to apply for the Graded Benefit Whole Life Plan if you are not eligible for Final Expense? ☐ Yes ☐ No

57. If you answered "Yes" to question 56, do you understand that a reduced death benefit may be payable during the first two certificate years according to the terms of the Graded Benefit Whole Life (GBWL) certificate? ☐ Yes ☐ No

58. Has the Proposed Insured ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for:

a) Amyotrophic Lateral Sclerosis (ALS), Huntington's Disease, Muscular Dystrophy or Systemic Lupus Erythematosus (Lupus)? ☐ Yes ☐ No

b) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

c) Alzheimer's Disease, dementia or mental retardation? ☐ Yes ☐ No

d) Amputation due to disease, or kidney failure, liver failure, organ transplant or cirrhosis of the liver? ☐ Yes ☐ No

59. Have you been diagnosed with a terminal illness which is expected to end your life within the next 12 months? ☐ Yes ☐ No

60. Are you confined to a bed or wheelchair, a hospital, a nursing home, or other long term care facility, or are you currently receiving home health care? ☐ Yes ☐ No

61. In the past 12 months, have you used oxygen equipment to assist in breathing (except when hospitalized)? ☐ Yes ☐ No

62. Are you currently waiting for a medical diagnosis or the results of medical tests which have not been received or been advised to have surgery requiring general anesthesia which has not been completed? ☐ Yes ☐ No

63. In the past 2 years have you had or have you taken medication for:

a) Complications of diabetes (such as eye or kidney disorder) or diabetes requiring insulin? ☐ Yes ☐ No

b) Hepatitis C, chronic hepatitis, chronic pancreatitis, or psychosis? ☐ Yes ☐ No

c) Internal cancer, melanoma, leukemia, multiple myeloma or lymphoma (including Hodgkin's disease)? ☐ Yes ☐ No

d) Parkinson's Disease or Multiple Sclerosis? ☐ Yes ☐ No

64. In the past 2 years have you had or have you taken medication for:

a) A Transient Ischemic Attack (TIA) or stroke? ☐ Yes ☐ No

b) Heart Attack, angina, atrial fibrillation, had surgery for aneurysm, any heart surgery (including angioplasty), or had a heart defibrillator inserted? ☐ Yes ☐ No

c) Cardiomyopathy, congestive heart failure, peripheral arterial disease, or a procedure to improve circulation? ☐ Yes ☐ No

d) Chronic Obstructive Pulmonary Disease (COPD) or emphysema? ☐ Yes ☐ No

65. In the past 2 years have you:

a) Used illegal drugs or used restricted or controlled drugs except as prescribed for you by a physician? ☐ Yes ☐ No

b) Been arrested 2 or more times for Driving Under the Influence (DUI) or had your driver's license revoked? ☐ Yes ☐ No

c) Been confined to a hospital more than 2 times? ☐ Yes ☐ No

d) Had treatment or been advised to have treatment for alcohol or drug abuse? ☐ Yes ☐ No

66. Do you need ongoing personal assistance performing bathing, dressing, eating, taking medications or moving around the house? ☐ Yes ☐ No

67. In the past 5 years have you been convicted of a felony or are you currently serving a term of parole or probation assigned by a court? ☐ Yes ☐ No

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, MIB, Inc. ("MIB"), 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. 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 a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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, and District

_____
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, Inc ("MIB")

Information regarding your insurability will be treated as confidential. Polish Roman Catholic Union of America, or its Reinsurer(s) may, however, make a brief report thereon to the MIB, a not-for profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of information it may have in your file by calling (866) 692-6901 or you can go to their website www.mib.com. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

POLISH ROMAN CATHOLIC UNION OF AMERICA, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

APPLICATION PART 4

AGENT'S REPORT

1. Agent Checklist

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

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

_____

_____

_____

_____

_____

_____

2. Remarks:

_____

_____

_____

_____

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

_____
DATE

_____
SALES REPRESENTATIVE'S NAME

_____
SALES REPRESENTATIVE'S SIGNATURE

_____
SALES REPRESENTATIVE'S CODE

_____
SALES REPRESENTATIVE'S PHONE NUMBER AND EMAIL

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

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

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

☐ Other (see instructions) ►

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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