



POLISH ROMAN CATHOLIC UNION OF AMERICA

A Fraternal Benefit Society

984 North Milwaukee Avenue, Chicago, IL 60642-4101
773-782-2600 - Fax 773-278-4595 - (800) 772-8632 - www.prcua.org

APPLICATION FOR LIFE INSURANCE

For Amount under \$25,000

PROPOSED INSURED'S INFORMATION:

1. Society # _____ Adult Juvenile

2. Name _____ 3. Male Female 4. Age _____
First Middle Last

5. Address _____ 6. Phone # (_____) _____
Street City State Zip

7. Date of Birth _____ 8. Soc. Sec. # _____ 9. Occupation _____

OWNER'S INFORMATION

10. Name _____ 11. Relationship _____ 12. Soc. Sec. # _____

13. Plan of Ins. _____ 14. Amount of Ins. \$ _____

15. Premium Amt.: Single \$ _____ Annual \$ _____ Semi Annual \$ _____ Quarterly \$ _____ Monthly \$ _____

16. Primary Beneficiary _____ 17. RELATIONSHIP _____

18. Contingent Beneficiary _____ 19. RELATIONSHIP _____

20. Is this insurance intended to replace any now in force? Yes No 21. Is Proposed Insured a PRCUA member? Yes No

22. Dividend election (choose one): Paid in Cash? Yes No Purchase Paid-Up Additions? Yes No

APPLICANT'S INFORMATION (IF PROPOSED INSURED IS A JUVENILE.)

23. Name _____ 24. Male Female
First Middle Last

25. Address _____ 26. Relationship _____ A
Street City State Zip

PERSONAL HEALTH STATEMENT OF PROPOSED INSURED

27. Height _____ Weight _____ 28. Doctor's Name _____

29. Dr.'s Address _____ 30. Dr.'s Phone # (_____) _____

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

32. In the past 5 years, has the proposed insured had or been treated for, or been advised to obtain treatment for 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

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

If you answered "YES" to questions 31-33, explain details below. Attach a separate page if additional space is needed.

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

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.

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 insurance certificate by the Union. 4) I AGREE that if I am not a member of the Union, this application serves as a membership application.

SIGNED AT _____ this _____ day of _____, 20 _____
City State

Proposed Insured's Signature (Must be 16 yrs. or older)

Applicant's Signature

Owner's Signature, if other than Proposed Insured

Witness/Authorized Representative

