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 _____
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 and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. Any certificate issued as a result of material misstatement or omission of facts may be voided and the company's only obligation shall be to return the premiums paid.

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

Home Office approval_____

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This Authorization complies with the HIPAA Privacy Rule

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including but not limited to, physicians, hospitals, clinics, medical practitioners and other medically related facilities) to disclose my medical records (including, but not limited to patient histories, progress notes, test results, x-rays and other diagnostic information) to the Polish Roman Catholic Union of America or its reinsurers for the purpose of:

Determination of Eligibility for Life Insurance

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or the Polish Roman Catholic Union of America has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to: **Polish Roman Catholic Union of America, ATTN: Privacy Comp. Officer, 984 N. Milwaukee Avenue, Chicago, Illinois 60642-4101**

This Authorization will expire six (6) months after the date upon which the Authorization was signed.

_____	_____	_____
Signature of Individual Whose Information is to be Disclosed	*Printed Name*	*Date*
_____	_____	_____
Signature of Parent or Legal Guardian (If Applicable)	*Printed Name*	*Date*

DISCLOSURE NOTICE - FAIR CREDIT REPORTING ACT

As part of our routine selection procedure, we may request that an investigative Consumer Report be made. These reports include information as to identify character, general reputation, personal characteristics, verification of residence, marital status, estimate of worth and income, occupation, avocations, general health, habits and mode of living. Information is obtained from several different sources. Confidential interviews may be conducted with neighbors, friends, associates and acquaintances. Personal discussions may be arranged with you or your family and public records may be carefully reviewed. Upon written request to the Underwriter at the PRCUA, further information on the nature and scope of the report will be provided. Our experience shows that information from investigative reports usually does not have an adverse effect upon our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting company. All of these rights are guaranteed to you by the Fair Credit Reporting Act, which took effect in April, 1971.

Notice to _____ _____

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

AGENT'S STATEMENT: To the best of my knowledge this insurance applied for ___will ___will not replace any existing life insurance or annuity. I further certify that any information recorded by me on the application is true and accurate to the best of my knowledge.

POLISH ROMAN CATHOLIC UNION OF AMERICA
Chicago, Illinois

_____ _____

Agent/Deputy Signature *Date*