



# 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 cancer, a 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

# 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.

**The Insured is entitled to receive a copy of this completed Authorization form.**

\_\_\_\_\_  
*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.

**POLISH ROMAN CATHOLIC UNION OF AMERICA**  
**Chicago, Illinois**

\_\_\_\_\_  
*Agent/Deputy Signature*

\_\_\_\_\_  
*Date*