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 773-278-4595 • www.PRCUA.org

SIMPLIFIED LIFE INSURANCE APPLICATION

FACE AMOUNTS TO $24,999

A - PROPOSED INSURED'S INFORMATION

1. New Member: ☐ Yes ☐ No **2.** ____________ Society | ______________________ Certificate - HOME OFFICE USE | ____________ Roster - HOME OFFICE USE | ☐ Medical Required

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

5. ________________________________ Street Address / City, State, Zip Code **6.** Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

7. ________________________________ Email Address **8.** ____________________ Telephone Number

9. ____________________ Date of Birth **10.** ________ Age **11.** ____________________ Birthplace

12. U.S. Citizen: ☐ Yes ☐ No **13.** ☐ SSN ☐ TIN ☐ EIN ____________________ **14.** Occupation ____________________

15. ________________________________ Proposed Insured's Driver's License Number / State Identification Number **16.** ________ State Issued **17.** ____________________ Expiry Date

HOME OFFICE USE - DO NOT WRITE IN THIS SPACE **Endorsements & Amendments**

B - OWNER'S INFORMATION

18. ________________________________ Name of Owner (First, MI, Last Name) **19.** Sex: ☐ M ☐ F **20.** ____________ Date of Birth

21. ________________________________ Owner's Street Address / City, State, Zip Code **22.** ____________________ Relationship to Proposed Insured

23. ________________________________ Owner's Email Address **24.** ____________________ Owner's Telephone Number

25. U.S. Citizen: ☐ Yes ☐ No **26.** ☐ SSN ☐ TIN ☐ EIN ____________________

27. ________________________________ Owner's Driver's License Number / State Identification Number **28.** ________ State Issued **29.** ____________________ Expiry Date

C - PLAN INFORMATION

30. Plan ____________________ **31.** Face Amount $____________________ **32.** Backdate to Save Age: ☐ Y ☐ N

33. Premium $______________ **34.** Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly **35.** ☐ ACH (complete form ACH1)

36. Riders*: ☐ GIO ☐ ADB ☐ WP ☐ JPB ** Not all riders are available with all plans*

37. In the event of a default in payment of any premium due, shall the automatic premium loan provision, if applicable, become effective in lieu of any non-forfeiture option? ☐ Yes ☐ No

38. Dividend election (choose one): ☐ Paid in cash ☐ Purchase Paid-Up Additions

39. Mail Certificate to: ☐ Sales Rep ☐ Owner ☐ Insured ☐ Applicant **40.** Send Billing Notices to: ☐ Insured ☐ Owner ☐ Applicant

D - APPLICANT/PAYOR'S INFORMATION

41. ________________________________ Name of Applicant (First, MI, Last Name) **42.** Sex: ☐ M ☐ F **43.** ____________ Date of Birth

44. ________________________________ Applicant's Street Address / City, State, Zip Code **45.** ____________________ Relationship to Proposed Insured

46. ________________________________ Applicant's Email Address **47.** ____________________ Applicant's Telephone Number

48. U.S. Citizen: ☐ Yes ☐ No **49.** ☐ SSN ☐ TIN ☐ EIN ____________________

50. ________________________________ Applicant's Driver's License Number / State Identification Number **51.** ____________ State Issued **52.** ____________ Expiry Date

E - ADDITIONAL LIFE INSURANCE INFORMATION

53. Excluding this application, amount of insurance currently pending with other companies (If none, state "None"): $________________

54. Of the above pending amount, how much do you intend to accept? $________________

55. List all insurance now in force or pending. If none, write "None". Have you, or do you intend to have any life insurance certificate replaced, converted, reissued, or otherwise discontinued because of this application? If "Yes", complete Replacement Form.

COMPANY	CERTIFICATE #	FACE AMOUNT	ISSUE DATE	ADB	REPLACING?	1035 EXCHANGE?
____________	________	$________	________	$________	☐ Yes ☐ No	☐ Yes ☐ No
____________	________	$________	________	$________	☐ Yes ☐ No	☐ Yes ☐ No
____________	________	$________	________	$________	☐ Yes ☐ No	☐ Yes ☐ No

F - BENEFICIARY INFORMATION

PRIMARY

56. Name ____________________ Relationship __________ % Share ______
☐ SSN ☐ TIN ☐ EIN ____________________ Birth Date ____________________

CONTINGENT

57. Name ____________________ Relationship __________ % Share ______
☐ SSN ☐ TIN ☐ EIN ____________________ Birth Date ____________________

G - PROPOSED INSURED'S HEALTH INFORMATION

58. Height: ________ feet ________ inches **59.** Weight: __________ **60.** Any recent weight loss or gain: ☐ Yes ☐ No

61. ____________________
HOW MUCH WEIGHT? LOSS/GAIN? REASON FOR CHANGE

62. ____________________
NAME OF PROPOSED INSURED'S PHYSICIAN (FIRST, MI, LAST NAME); IF NONE, STATE "NONE"

63. ____________________ **64.** ____________________
PHYSICIAN'S STREET ADDRESS / CITY, STATE, ZIP CODE — PHYSICIAN'S TELEPHONE NUMBER

65. ____________________
DATE LAST SEEN; REASON, RESULTS OF VISIT

66. Has the Proposed Insured smoked or used tobacco in any form in the last twelve (12) months? ☐ Yes ☐ No

67. ____________________ **68.** ____________________
TYPE OF TOBACCO USED — LAST USE OF TOBACCO - MM/YYYY

FOR QUESTIONS 69-72, IF "YES", PLEASE GIVE COMPLETE DETAILS UNDER REMARKS BELOW.

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

70. 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, mental illness, or drug and alcohol dependency? ☐ Yes ☐ No

71. Are you now taking any medication prescribed by a physician? ☐ Yes ☐ No

72. Proposed Insured's Family History

	Age, If Living	Cause Of Death	Age At Death
Father			
Mother			
Brothers: No. Living _______ No. Dead _______			
Sisters: No. Living _______ No. Dead _______			

REMARKS: If you answered "Yes" to any question in the "Proposed Insured's Health Information" Section, explain details below. Attach a separate page if additional space is needed.

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

H - ILLUSTRATION CERTIFICATION

This section must be completed if a matching NAIC compliant illustration is not being submitted with this application.

☐ An Illustration for the certificate applied for was not presented to me.
I understand that an Illustration conforming to the issued certificate will be provided to me at the time of delivery of the certificate. It will then be signed, returned to the PRCUA Home Office and become part of my application for membership.

☐ An Illustration was used in the sales presentation, but it was different from the actual certificate applied for.
I understand that an Illustration conforming to the issued certificate will be provided to me at the time of delivery of the certificate. It will then be signed, returned to the PRCUA Home Office and become part of my application for membership.

☐ I certify that I viewed a computer generated Illustration on a computer display screen conforming to the application submitted.
I understand that a printed Illustration that complies with the state requirements will be provided to me at the time of delivery of the certificate. It will then be signed, returned to the PRCUA Home Office and become part of my application for membership.

I - AGREEMENTS & SIGNATURES

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

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION: POLISH ROMAN CATHOLIC UNION OF AMERICA IS LICENSED TO DO BUSINESS IN THE STATE OF ILLINOIS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN THE ILLINOIS LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOWN AS THE 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.

SIGNED AT ______________________________ this __________ day of ____________________, 20_______

Proposed Insured's Signature (Age 16 & Up)	Owner's Signature, if Other Than Proposed Insured
Applicant's Signature, if Other Than Proposed Insured	Sales Representative's Signature
(Print) Sales Representative's Name, Code, and District	Sales Representative's Phone Number & Email

Home Office Approval - HOME OFFICE USE ONLY

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 (Age 16 & Up) 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

____________________________________ ____________________

Sales Representative's Signature Date

HIPAA COMPLIANT AUTHORIZATION
FOR RELEASE OF MEDICAL INFORMATION

____ ____________________

PROPOSED INSURED'S NAME (FIRST, MI, LAST NAME) DATE OF BIRTH (MM/DD/YYYY)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past five (5) years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Polish Roman Catholic Union of America may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Polish Roman Catholic Union of America.

This authorization shall remain in force for 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Polish Roman Catholic Union of America has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the recipient except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Polish Roman Catholic Union of America may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I agree that a photo static copy of this authorization shall be considered as effective and valid as the original.

____ ____________________

SIGNATURE OF PROPOSED INSURED/PATIENT OR PERSONAL REPRESENTATIVE DATE (MM/DD/YYYY)

____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY OR RELATIONSHIP TO PATIENT