



Polish Roman Catholic Union of America

A Fraternal Benefit Society

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

- NEW MEMBER
 ADDITIONAL INSURANCE

INSURANCE APPLICATION

- ADULT JUVENILE
 MEDICAL REQUIRED

PROPOSED INSURED INFORMATION (PRINT CLEARLY)

1. NAME _____ 2. SEX _____

 First Middle Last

3. ADDRESS _____

 Street _____

 City State Zip

4. DATE OF BIRTH _____ 5. ISSUE AGE _____ 6. PLACE OF BIRTH _____

7. MARITAL STATUS SINGLE MARRIED WIDOWED

8. SOCIAL SECURITY # _____ 9. MAIDEN NAME _____

10. AREA CODE AND TELEPHONE # () _____ 11. E-MAIL ADDRESS _____

12. NAME OF EMPLOYER _____

13. ADDRESS _____

 Street _____

 City State Zip

14. PRESENT OCCUPATION _____

15. LENGTH OF EMPLOYMENT _____

16. PLAN DESCRIPTION _____ PLAN CODE _____

17. AMOUNT OF INSURANCE _____

18. ADDITIONAL RIDERS
 A. ACCIDENTAL DEATH BENEFIT (ADB) B. WAIVER OF PREMIUM (WP)
 C. RETURN OF PREMIUM (RP) D. GUARANTEED INSURABILITY
 E. JUVENILE PAYOR BENEFIT (JPB) OPTION (GIO)
 AMOUNT OF OPTION \$ _____
 F. _____ YEAR DECREASING TERM \$ _____
 G. _____ YEAR LEVEL TERM \$ _____

19. PREMIUM PAYMENT
 ANNUAL SEMI-ANNUAL QUARTERLY
 MONTHLY SINGLE PAYMENT _____
 AMOUNT PAID \$ _____

20. DIVIDEND OPTION
 Paid up additions Paid in cash Accumulate at interest Reduce premium

21. APPLICANT INFORMATION (If Proposed Insured is a juvenile.)
 NAME _____

 First Middle Last
 ADDRESS _____

 Street _____

 City State Zip
 SOCIAL SECURITY # _____
 AREA CODE AND TELEPHONE # () _____
 RELATION TO PROPOSED INSURED _____

22. SOCIETY # _____

23. FOR HOME OFFICE USE ONLY
 CERTIFICATE # _____ ROSTER # _____

 CORRECTIONS AND AMENDMENTS
 (Do not write in this space.)

24. Has the Proposed Insured smoked or used tobacco in any form in the last twelve (12) months? YES NO *If yes, type of tobacco* _____
 Month and year last used _____

25. Are you now a member of the PRCUA? YES NO
 IF YES, SOCIETY # _____ ROSTER # _____

26. BENEFICIARY(IES)
 PRIMARY (Full Name) _____ Relationship _____
 1. _____
 2. _____
 3. _____

CONTINGENT (Full Name) _____ Relationship _____
 1. _____
 2. _____
 3. _____

27. 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 nonforfeiture options? YES NO

28. SECONDARY ADDRESSEE (for notification of past due premium payment and possible lapse in coverage)
 NAME _____

 First Middle Last
 ADDRESS _____

 Street _____

 City State Zip

29. OWNER INFORMATION Unless otherwise specified below, the owner of adult insurance is the Proposed Insured and the owner of juvenile insurance is the applicant until age 16.
 NAME _____

 First Middle Last
 ADDRESS _____

 Street _____

 City State Zip
 SOCIAL SECURITY # OR EIN # _____
 AREA CODE AND TELEPHONE # () _____
 RELATION TO PROPOSED INSURED _____

PERSONAL HEALTH STATEMENT (Complete at all times.)

1. PROPOSED INSURED'S HEIGHT _____ feet _____ inches WEIGHT _____ lbs.
 Any recent weight loss or gain? YES NO *If yes, explain:* _____

2. FAMILY HISTORY OF PROPOSED INSURED <small>"To the best of your knowledge and belief"</small>		Age, if Living	Age at Death	Present Health Condition or Cause and Date of Death
Father				
Mother				
Husband or Wife				
Brothers	No.			
Sisters	No.			

FOR QUESTIONS BELOW, IF "YES", PLEASE GIVE COMPLETE DETAILS UNDER REMARKS ON PAGE 3.

3. Within the past five (5) years, has the Proposed Insured: **YES NO**
- A. Been charged with a driving while impaired (alcohol, drugs, other) violation, had a driver's license revoked or suspended or within the last twenty-four (24) months received 3 or more citations for moving traffic violations?
If yes, give date, violation, state and driver's license number
 - B. Had an application for life or health insurance declined, postponed, rated or modified?
If yes, name company, date and action taken.
 - C. Flown as a pilot, student pilot, crew member or flights in other than commercial aircraft?
 - D. Engaged in parachuting, racing or intend to do so?
 - E. Used cocaine, barbiturates, intravenous drugs, hallucinogens, sought advice or treatment for alcohol or drug use by a licensed member of the medical profession?
4. Has the Proposed Insured:
- A. Had any surgical operations?
 - B. Been in a hospital, sanitarium or other institution for observation, rest, diagnosis or treatment?
5. Has the Proposed Insured ever had, or been told he or she had, or received treatment or advice from a physician or someone in the medical field for:
- A. Abnormal blood pressure, coronary artery disease or any other disorder or disease of the heart, blood vessels, or cardiovascular system, stroke or any other disease of the cerebrovascular system?
 - B. Cancer, tumor or any other growth or malignancy?
 - C. Diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder?
 - D. Any nose, throat, lung or any other respiratory disorder?
 - E. Any disorder of the stomach, intestines, rectum, liver or pancreas?
 - F. Any injury to or disease of the bones, muscles, joints, eyes or skin, including arthritis?
 - G. Epilepsy, seizures, brain disorder or any other disease or disorder of the nervous system?
 - H. Anxiety, depression or an emotional, behavioral, mental or nervous disorder?
 - I. Any disease or disorder of the kidney, bladder or genital organs or system?
 - J. Has been tested positive for exposure to the HIV infection HIV antibodies in a test taken for the purpose of obtaining insurance or whether the applicant has been diagnosed by a physician as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?
6. Other than as disclosed in the answers above, has the Proposed Insured within the past five (5) years:
- A. Received treatment or advice from, been prescribed medication by any other physician or medical facility?
If yes, state date, reason, ordered by whom and results.
 - B. Had any abnormal diagnostic tests done by a licensed member of the medical profession?
 - C. Made claim for or received benefits, compensation, or a pension due to sickness or injury?
 - D. Had any known indication of any other physical disorder or abnormality performed by a licensed member of the medical profession?
7. To the best of your knowledge and belief, has any of the Proposed Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer, stroke or any other hereditary disease?
If yes, indicate family member and disease. _____

PROPOSED INSURED'S LIFE INSURANCE STATUS

1. Is this life insurance to replace any now in force? YES NO *If yes, state which and give reason.* _____

2. LIST ALL LIFE INSURANCE ON PROPOSED INSURED

Company	Face Amount	Accidental Death Amount	Year Issued	List Certificate # (if PRCUA)
A.				
B.				

3. Are negotiations now pending for life insurance on the Proposed Insured with any other company? YES NO

PROPOSED INSURED'S PHYSICIAN OR HEALTH CARE FACILITY:

NAME OF PHYSICIAN OR HEALTH CARE FACILITY _____ AREA CODE AND TELEPHONE # _____
()

ADDRESS _____

Street _____ City _____ State _____ Zip _____

REMARKS: Give complete details below for all questions answered "YES". Give question number (and letter), include dates, length of illness or injury, names and addresses of hospitals and doctors consulted. Attach additional page, if more space is needed.

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.

- 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.
- 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.
- 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.
- 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 Applicant's Signature

 Owner's Signature, if other than Proposed Insured Witness/Authorized Representative

HOME OFFICE APPROVAL
 This application is hereby:

