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 (First Middle Last) | 2. SEX

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. SPECIAL REQUESTS

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	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.

	YES	NO
3. Within the past five (5) years, has the Proposed Insured:		
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 other hazardous sports or intend to do so?	☐	☐
E. Used cocaine, barbiturates, intravenous drugs, hallucinogens, sought advice or treatment for alcohol or drug use?	☐	☐
F. Does the Proposed Insured intend to travel or reside outside the United States?	☐	☐
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. Any immune system disease or disorder (including AIDS or positive HIV test)?	☐	☐
6. Other than as disclosed in the answers above, has the Proposed Insured within the past five (5) years:		
A. Consulted, 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?	☐	☐
C. Been aware of any symptoms for which a physician has not been consulted?	☐	☐
D. Made claim for or received benefits, compensation, or a pension due to sickness or injury?	☐	☐
E. Had any known indication of any other physical disorder or abnormality?	☐	☐
7. 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.

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 Applicant's Signature

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

HOME OFFICE APPROVAL
This application is hereby:

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 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 Compliance Officer, 984 N. Milwaukee Avenue, Chicago, Illinois 60642-4101**

This Authorization will expire twenty-four (24) 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

This Notice Must be Given to Proposed Insured.

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 *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) a completed application has been received by the Union or its Agent. The temporary insurance shall remain inforce until there is notification in writing of being declined and a refund of any unearned premium is paid.

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*