



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 <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> 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) <input type="checkbox"/>		B. WAIVER OF PREMIUM (WP) <input type="checkbox"/>
C. RETURN OF PREMIUM (RP) <input type="checkbox"/>		D. GUARANTEED INSURABILITY <input type="checkbox"/>
E. JUVENILE PAYOR BENEFIT (JPB) <input type="checkbox"/>		OPTION (GIO) <input type="checkbox"/>
AMOUNT OF OPTION \$ _____		
F. _____ YEAR DECREASING TERM \$ _____		
G. _____ YEAR LEVEL TERM \$ _____		
19. PREMIUM PAYMENT		
<input type="checkbox"/> ANNUAL <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY		
<input type="checkbox"/> MONTHLY <input type="checkbox"/> SINGLE PAYMENT <input type="checkbox"/>		
AMOUNT PAID \$ _____		
20. DIVIDEND OPTION		
<input type="checkbox"/> Paid up additions <input type="checkbox"/> Paid in cash <input type="checkbox"/> Accumulate at interest <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, type of tobacco</i> _____ Month and year last used _____	
25. Are you now a member of the PRCUA? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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.

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?
- 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 willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- 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:

