



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 _____

3. ADDRESS _____
First Middle Last

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.

3. Within the past five (5) years, has the Proposed Insured:
- | | | |
|--|------------|-----------|
| | YES | NO |
|--|------------|-----------|
- A. Been convicted of 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?
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? (excluding HIV 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 AND APPLICANT Attach additional page, if more space is needed.

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.

- 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 and By-Laws of the Union, which are now in force or may hereafter be adopted by the Union.
- I AGREE** that if I am not a member of the Union, this application serves as a membership application. This application is to be attached to and made part of the Certificate of Insurance applied for.

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.

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) 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* _____