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

APPLICATION FOR LIFE INSURANCE

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. _____ (Name of Employer) **16.** _____ (Employer's Street Address / City, State, Zip Code)

17. _____ (Proposed Insured's Driver's License Number / State Identification Number) **18.** _____ (State Issued) **19.** _____ (Expiry Date)

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

B - OWNER'S INFORMATION

20. Owner is: ☐ Proposed Insured ☐ Trust (also complete Questions 33-36) ☐ Other than Proposed Insured or Trust

21. _____ (Name of Owner (First, MI, Last Name)) **22.** Sex: ☐ M ☐ F **23.** _____ (Date of Birth)

24. _____ (Owner's Street Address / City, State, Zip Code) **25.** _____ (Relationship to Proposed Insured)

26. _____ (Owner's Email Address) **27.** _____ (Owner's Telephone Number)

28. U.S. Citizen: ☐ Yes ☐ No **29.** ☐ SSN ☐ TIN ☐ EIN _____

30. _____ (Owner's Driver's License Number / State Identification Number) **31.** _____ (State Issued) **32.** _____ (Expiry Date)

If Certificate is Trust Owned:

33. _____ (Name of Trust) **34.** _____ (Trust Tax ID Number)

35. _____ (Complete Name of Trustees) **36.** _____ (Date of Trust (Attach First & Last Page of Trust))

C - PLAN INFORMATION

37. Plan _____ **38.** Face Amount $_____ **39.** Backdate to Save Age: ☐ Y ☐ N

40. Premium $_____ **41.** Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly **42.** ☐ ACH (complete form ACH1)

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

44. 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

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

46. Mail Certificate to: ☐ Sales Rep ☐ Owner ☐ Insured ☐ Applicant **47.** Send Billing Notices to: ☐ Insured ☐ Owner ☐ Applicant

D - APPLICANT/PAYOR'S INFORMATION

48. _____ (Name of Applicant (First, MI, Last Name)) **49.** Sex: ☐ M ☐ F **50.** _____ (Date of Birth)

51. _____ (Applicant's Street Address / City, State, Zip Code) **52.** _____ (Relationship to Proposed Insured)

53. _____ (Applicant's Email Address) **54.** _____ (Applicant's Telephone Number)

55. U.S. Citizen: ☐ Yes ☐ No **56.** ☐ SSN ☐ TIN ☐ EIN _____

57. _____ (Applicant's Driver's License Number / State Identification Number) **58.** _____ (State Issued) **59.** _____ (Expiry Date)

E - ADDITIONAL LIFE INSURANCE INFORMATION

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

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

62. 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 (If Trust, Attach First & Last Page of Trust)

PRIMARY

63. Name _____ Relationship _____ % Share _____
Trustees (if applicable) _____
☐ SSN ☐ TIN ☐ EIN _____ Birth/Trust Date _____
Name _____ Relationship _____ % Share _____
Trustees (if applicable) _____
☐ SSN ☐ TIN ☐ EIN _____ Birth/Trust Date _____

CONTINGENT

64. Name _____ Relationship _____ % Share _____
Trustees (if applicable) _____
☐ SSN ☐ TIN ☐ EIN _____ Birth/Trust Date _____
Name _____ Relationship _____ % Share _____
Trustees (if applicable) _____
☐ SSN ☐ TIN ☐ EIN _____ Birth/Trust Date _____

G - PROPOSED INSURED'S HEALTH INFORMATION

65. Height: _____ feet _____ inches **66.** Weight: _____ **67.** Any recent weight loss or gain: ☐ Yes ☐ No

68. _____
How Much Weight? Loss/Gain? Reason For Change

69. _____
Name of Proposed Insured's Physician (First, MI, Last Name); if None, State "None"

70. _____ **71.** _____
Physician's Street Address / City, State, Zip Code | Physician's Telephone Number

72. _____
Date Last Seen; Reason, Results of Visit

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

74. _____ **75.** _____
Type of Tobacco Used | Last Use of Tobacco - MM/YYYY

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

76. Within the past five (5) years, has the Proposed Insured:

A. Been charged with driving while impaired (alcohol, drugs, other) violation, had a driver's license revoked or suspended or within the last twenty-four (24) months received three (3) or more citations for moving traffic violations? ☐ Yes ☐ No
B. Flown as a pilot, student pilot, crew member, or flights in other than commercial aircraft? ☐ Yes ☐ No
C. Engaged in parachuting, racing, or other hazardous sports or intend to do so? ☐ Yes ☐ No
D. Does the Proposed Insured intend to travel or reside outside the United States? ☐ Yes ☐ No

77. Has the Proposed Insured ever:

A. Had an application for life or health insurance declined, postponed, rated, or modified? ☐ Yes ☐ No
B. Used cocaine, barbiturates, intravenous drugs, hallucinogens, sought advice, or treatment for alcohol or drug use? ☐ Yes ☐ No
C. Had any surgical operations? ☐ Yes ☐ No
D. Been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? ☐ Yes ☐ No

78. Has the Proposed Insured ever seen a physician, been diagnosed with, or treated 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? ☐ Yes ☐ No
B. Cancer, tumor, or any other growth, or malignancy? ☐ Yes ☐ No
C. Diabetes, thyroid disorder, anemia, hepatitis, or any other blood, or glandular disorder? ☐ Yes ☐ No
D. Any nose, throat, lung, or any other respiratory disorder, including sleep apnea? ☐ Yes ☐ No
E. Any disorder of the stomach, intestines, rectum, liver, or pancreas? ☐ Yes ☐ No
F. Any injury to, or disease of the bones, muscles, joints, eyes, or skin, including arthritis? ☐ Yes ☐ No
G. Epilepsy, seizures, brain disorder, or any other disease or disorder of the nervous system? ☐ Yes ☐ No
H. Anxiety, depression, or an emotional, behavior, mental, or nervous disorder? ☐ Yes ☐ No
I. Any disease or disorder of the kidney, bladder, or genital organs or system? ☐ Yes ☐ No
J. Any immune system disease or disorder (including AIDS or positive HIV test)? ☐ Yes ☐ No

G - PROPOSED INSURED'S HEALTH INFORMATION

(continued from page 2)

79. Has 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, age at diagnosis, and disease.* _____

_____

80. 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)

_____
APPLICANT'S SIGNATURE, IF OTHER THAN PROPOSED INSURED

_____
OWNER'S SIGNATURE, IF OTHER THAN PROPOSED INSURED

_____
(PRINT) SALES REPRESENTATIVE'S NAME, CODE, AND DISTRICT

_____
SALES REPRESENTATIVE'S SIGNATURE

_____
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

SALES REPRESENTATIVE REPORT

1. Has any insurance in force or applied for on the life of the proposed insured terminated within the past three months or is termination of such insurance contemplated as a result of the issuance of the life insurance applied for?

   ☐ Yes ☐ No

   If yes, have you complied with the Union's and your state's requirements regarding replacement?

   ☐ Yes ☐ No

2. Have you issued a receipt with this application?

   ☐ Yes ☐ No

_____ _____

OWNER'S INCOME (EARNED) OWNER'S NET WORTH

3. REMARKS/SPECIAL REQUESTS: _____

_____

_____

_____

I certify that on the date shown below:

1. The application was completed and signed in my presence by the proposed insured, or the owner, if other than the proposed insured;

2. I have asked each question on the application and I have honestly and accurately recorded the answers supplied by the proposed insured, or the owner, if other than the proposed insured.

_____ _____

DATE SALES REPRESENTATIVE'S SIGNATURE & CODE (MUST BE SIGNED IN EVERY CASE)

_____ _____

SALES REPRESENTATIVE'S PHONE NUMBER SALES REPRESENTATIVE'S EMAIL ADDRESS