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

INSURANCE APPLICATION

[X] NEW MEMBER
[ ] ADDITIONAL INSURANCE

[X] ADULT [ ] JUVENILE
[X] MEDICAL REQUIRED

PROPOSED INSURED INFORMATION (PRINT CLEARLY)

1. NAME: Jane (First) C. (Middle) Doe (Last)
2. SEX: F
3. ADDRESS: 123 Lee Street (Street), Chicago (City), IL (State), 60625 (Zip)
4. DATE OF BIRTH: 5/1/1981
5. ISSUE AGE: 33
6. PLACE OF BIRTH: IL
7. MARITAL STATUS: [ ] SINGLE [X] MARRIED [ ] WIDOWED
8. SOCIAL SECURITY #: 999-99-9999
9. MAIDEN NAME: Smith
10. AREA CODE AND TELEPHONE #: (411) 222-1144
11. E-MAIL ADDRESS: jane@gmail.com
12. NAME OF EMPLOYER: Corey Industries
13. ADDRESS: 66 Front Street (Street), Chicago (City), IL (State), 60633 (Zip)
14. PRESENT OCCUPATION: Supervisor
15. LENGTH OF EMPLOYMENT: 10 Years
16. PLAN DESCRIPTION: 20 Year Whole Life — PLAN CODE: 2220
17. AMOUNT OF INSURANCE: $ 75,000
18. ADDITIONAL RIDERS
    - A. ACCIDENTAL DEATH BENEFIT (ADB) [X]
    - B. WAIVER OF PREMIUM (WP) [ ]
    - C. RETURN OF PREMIUM (RP) [ ]
    - D. GUARANTEED INSURABILITY OPTION (GIO) [ ]
    - E. JUVENILE PAYOR BENEFIT (JPB) [ ]
    - AMOUNT OF OPTION $ 85
    - F. ______ YEAR DECREASING TERM $ ______
    - G. ______ YEAR LEVEL TERM $ ______
19. PREMIUM PAYMENT: [ ] ANNUAL [X] SEMI-ANNUAL [ ] QUARTERLY [ ] MONTHLY [ ] SINGLE PAYMENT [ ]
    AMOUNT PAID $ 673.66
20. DIVIDEND OPTION: [X] 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 # 411

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 [X] NO *If yes, type of tobacco* ______
    Month and year last used ______

25. Are you now a member of the PRCUA? [ ] YES [X] NO
    IF YES, SOCIETY # ______ ROSTER # ______

26. BENEFICIARY(IES)

PRIMARY (Full Name)	Relationship
1. John C. Doe	Spouse
2.	
3.	

CONTINGENT (Full Name)	Relationship
1. Mary J. Doe	Daughter 50%
2. James J. Doe	Son 50%
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? [X] 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: John (First) C (Middle) Doe (Last)
    ADDRESS: 123 Lee Street (Street), Chicago (City), IL (State), 60625 (Zip)
    SOCIAL SECURITY # OR EIN # 222-11-2222
    AREA CODE AND TELEPHONE # (411) 222-1144
    RELATION TO PROPOSED INSURED Spouse

SAMPLE

PERSONAL HEALTH STATEMENT (Complete at all times.)

1. PROPOSED INSURED'S HEIGHT 5 feet 4 inches WEIGHT 120 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		70		Good
Mother		68		Good
Husband or Wife		36		Good
Brothers No.		32		Good
Sisters No.		36		Good

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.* ______	☐	☒

SAMPLE

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.	ABC Life	$ 50,000.00	$ 0.00	2004	
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: Dr. Susan Smith

AREA CODE AND TELEPHONE #: (411) 222-1117

ADDRESS: 40 Locust Street Oak Park IL 60077

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.

4A: 2010-Rotator Cuff Surgery. Full recovery. Dr. Hansen, 4600 N. Harlem Avenue, Chicago, IL 60632 773-789-9600

5C: May 2008-Hypothyroid. Controlled with Synthroid 10 MG daily. Dr. Lewis, 4000 N. Harlem Avenue, Chicago, IL 60632 773-789-9600

6A: 2013-Routine physical exam-All normal-Dr. Smith (PCP)

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 Chicago, IL this 20 day of March, 20 14

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:

SAMPLE

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 thirty (30) months after the date upon which the Authorization was signed.

	Jane C. Doe	
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 $ 225.00 from Jane C. Doe on the Life of: Jane C. Doe

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*

POLISH ROMAN CATHOLIC UNION OF AMERICA 984 N Milwaukee Ave • Chicago IL • 60642-4101

ILLUSTRATION CERTIFICATION

This form must be completed and submitted with an application if a matching printed and signed NAIC compliant illustration is not being submitted. Please ✓ either Section 1, Section 2, or Section 3 as it applies to the submitted application. This form must be signed by both the Applicant and Sales Representative.

For additional information, please contact us at ☎ 1-800-772-8632 or visit our website at www.prcua.org.

SECTION 1 – NO ILLUSTRATION WAS USED

☒ 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.

SECTION 2 – ILLUSTRATION USED IN PRESENTATION DID NOT CONFORM TO THE APPLICATION

☐ 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.

PLEASE PRINT IN THE BLOCKS WITH CAPITAL LETTERS

SECTION 3 – DISPLAYED COMPUTER ILLUSTRATION CERTIFICATION

☐ 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. The Illustration was based on the following personal and policy information.

Gender: ☐ Male ☐ Female Age: Initial Death Benefit: $, ,

Underwriting (Rate) Class: ☐ Standard Tobacco ☐ Standard Non-Tobacco ☐ Preferred Tobacco ☐ Preferred Non-Tobacco

PLAN

DIVIDEND OPTION

ADDITIONAL RIDER(S)

PLEASE PRINT IN THE BLOCKS WITH CAPITAL LETTERS

SIGNATURES

J A N E C . D O E

APPLICANT'S NAME

☒ SIGNATURE OF APPLICANT ☒ SIGNATURE DATE

A G E N T N A M E

SALES REPRESENTATIVE'S NAME

☒ SIGNATURE OF SALES REPRESENTATIVE ☒ SIGNATURE DATE

SAMPLE

984 N Milwaukee Ave · Chicago IL · 60642-4101

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

J A N E C . D O E

PROPOSED INSURED'S FIRST (MI) LAST NAME

5 / 1 / 1 9 8 1

DATE OF BIRTH (MM/DD/YYYY)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past five (5) years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Polish Roman Catholic Union of America may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Polish Roman Catholic Union of America.

This authorization shall remain in force for 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Polish Roman Catholic Union of America has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the recipient except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Polish Roman Catholic Union of America may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I agree that a photo static copy of this authorization shall be considered as effective and valid as the original.

☒ ______________________________

SIGNATURE OF PROPOSED INSURED/PATIENT OR PERSONAL REPRESENTATIVE

3/20/2014

DATE (MM/DD/YYYY)

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY OR RELATIONSHIP TO PATIENT

SAMPLE

POLISH ROMAN CATHOLIC UNION OF AMERICA

984 N. Milwaukee Avenue, Chicago, Illinois 60622-4101 - (773) 782-2600, Fax (773) 278-4595, Toll-free (800) 772-8632

PRCUA VERIFICATION CHECKLIST

(Complete after Interview/Application Process. Please PRINT.)

New Member? Yes [X] No [ ] Society Number 411

Renewing Member? Yes [ ] No [X] Roster Number

Insured's Name JANE C. DOE

Address 123 LEE STREET

City CHICAGO State IL Zip 60625

Telephone (Home) (411) 222-1144 (Work)

(Cell) Email JANE@GMAIL.COM

VERIFICATION OF IDENTIFICATION

Passport No. Driver's License State IL No. D171-0000-1122

State-Issued ID No. and State

Student ID No. and Institution

If Insured's name is different than the Applicant, indicate the name and address of the Applicant and their relationship to Insured.

Applicant's Name JOHN C. DOE

Address 123 LEE STREET

City CHICAGO State IL Zip 60625

Telephone (Home) (411) 222-1144 (Work)

(Cell) Email

Relationship of Applicant to Insured: Parent [ ] Grandparent [ ] Other SPOUSE

TYPE OF TRANSACTION

New Life Insurance [X] Dollar Amount $ $ 674

New Annuity [ ] Existing Annuity [ ] Dollar Amount $

METHOD OF PAYMENT

Personal Check X Business Check ____ Money Order ____ Cash ____

For Cash transactions exceeding $3,000.00 indicate the amount of each denomination of currency received:

$____ Amt.____; $____ Amt.____; $____ Amt.____; $____ Amt____; $____ Amt.____; $____ Amt____

Comments:

Signature of Authorized Representative PLEASE INCLUDE YOUR DEPUTY #
Agent/Deputy Number

Printed Name AGENT NAME Date: 3/20/2014

Telephone No. (224) 333-5454 Email AGENT NAME@EMAIL.COM

Home Office Use Only

Verified by ____ Date ____ App. No. ____

Form VCL-1

SAMPLE