POLISH ROMAN CATHOLIC UNION OF AMERICA

A Fraternal Benefit Society

984 North Milwaukee Avenue, Chicago, IL 60642-4101
773-782-2600 - Fax 773-278-4595 - (800) 772-8632 - www.prcua.org

APPLICATION FOR LIFE INSURANCE
For Amount under $25,000

PROPOSED INSURED'S INFORMATION: 1. Society # 411 Adult ☒ Juvenile ☐

2. Name JANE (First) C. (Middle) DOE (Last) 3. Male ☐ Female ☒ 4. Age 19

5. Address 123 LEE STREET (Street) CHICAGO (City) IL (State) 60625 (Zip) 6. Phone # (411) 222-1144

7. Date of Birth 12/25/1994 8. Soc. Sec. # 999-99-9999 9. Occupation STUDENT

OWNER'S INFORMATION

10. Name JOHN C. DOE 11. Relationship FATHER 12. Soc. Sec. # 222-11-2222

13. Plan of Ins. 20 LIMITED WHOLE LIFE 14. Amount of Ins. $ 20,000

15. Premium Amt.: Single $ ______ Annual $ ______ Semi Annual $ 225 Quarterly $ ______ Monthly $ ______

16. Primary Beneficiary JOHN C. DOE 17. RELATIONSHIP FATHER

18. Contingent Beneficiary MARY J. DOE 19. RELATIONSHIP MOTHER

20. Is this insurance intended to replace any now in force? Yes ☐ No ☒ 21. Is Proposed Insured a PRCUA member? Yes ☐ No ☒

22. Dividend election (choose one): Paid in Cash? Yes ☐ No ☒ Purchase Paid-Up Additions? Yes ☒ No ☐

APPLICANT'S INFORMATION (IF PROPOSED INSURED IS A JUVENILE.)

23. Name ______ (First) ______ (Middle) ______ (Last) 24. Male ☐ Female ☐

25. Address ______ 26. Relationship ______

PERSONAL HEALTH STATEMENT OF PROPOSED INSURED

27. Height 5'4" Weight 120 28. Doctor's Name DR. SUSAN SMITH

29. Dr.'s Address 40 LOCUST STREET 30. Dr.'s Phone # (411) 222-1117

31. Is Proposed Insured currently hospitalized, bedridden or confined to a wheel chair? Yes ☐ No ☒

32. In the past 5 years, has the proposed insured had or been treated for, or been advised to obtain treatment for medical or surgical condition including cancer, heart condition, kidney and liver disease, vascular disease, diabetes, muscular condition, stroke, elevated cholesterol, or drug and alcohol dependency? Yes ☐ No ☒

33. Has Proposed Insured used any form of tobacco in the last 12 months? Yes ☐ No ☒

If you answered "YES" to questions 31-33, explain details below. Attach a separate page if additional space is needed.

Date	Name and Address of Physician and Hospital	Specific Reason & Results

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 ______ (City) ______ (State) this ______ day of ______, 20 ______

______ Proposed Insured's Signature (*Must be 16 yrs. or older*)

______ Applicant's Signature

______ Owner's Signature, if other than Proposed Insured

______ Witness/Authorized Representative

Home Office approval ______

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

This Authorization will expire six (6) 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

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 (Must be 16 yrs. or older) *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 JOHN 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*

SAMPLE

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

POLISH ROMAN CATHOLIC UNION OF AMERICA

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.

3/20/2014

SIGNATURE OF PROPOSED INSURED/PATIENT OR PERSONAL REPRESENTATIVE

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 $ $ 225

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: ______

______   PLEASE INCLUDE YOUR DEPUTY #

Signature of Authorized Representative   *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