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

EXPRESS LIFE APPLICATION

PROPOSED INSURED'S INFORMATION

☐ Adult ☐ Juvenile **1.** _____ Society

_____ Certificate - HOME OFFICE USE _____ Roster - HOME OFFICE USE

2. _____ Name (First, MI, Last Name)

3. _____ Street Address / City, State, Zip Code

4. Sex: ☐ Male ☐ Female **5.** _____ Date of Birth **6.** _____ Age

7. ☐ SSN ☐ TIN ☐ EIN # _____ **8.** _____ Occupation

9. _____ Email Address **10.** _____ Telephone Number

11. _____ Proposed Insured's Driver's License Number / State Identification Number **12.** _____ State Issued **13.** _____ Expiration Date

OWNER'S INFORMATION (IF OTHER THAN PROPOSED INSURED)

14. _____ Name (First, MI, Last Name) **15.** _____ Relationship to Proposed Insured

16. ☐ SSN ☐ TIN ☐ EIN # _____

17. _____ Email Address **18.** _____ Telephone Number

PLAN INFORMATION

19. _____ Plan of Insurance **20.** _____ Amount of Insurance

21. Premium $_____ **22.** Mode: ☐ Single ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

23. Riders*: ☐ GIO ☐ ADB ☐ WP ☐ JPB *Not all riders are available with all plans **24.** ☐ ACH (complete form ACH1)

25. In the event of 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

26. Is Proposed Insured a PRCUA Member? ☐ Yes ☐ No

27. Dividend Election (choose one): ☐ Paid in Cash ☐ Purchase Paid-Up Additions

BENEFICIARY INFORMATION

28. PRIMARY (Name) _____

☐ SSN ☐ TIN ☐ EIN # _____ Relationship _____

29. CONTINGENT (Name) _____

☐ SSN ☐ TIN ☐ EIN # _____ Relationship _____

APPLICANT'S INFORMATION (IF OTHER THAN PROPOSED INSURED OR OWNER)

30. _____ Name (First, MI, Last Name) **31.** Sex: ☐ Male ☐ Female

32. _____ Street Address / City, State, Zip Code **33.** _____ Relationship to Proposed Insured

34. _____ Email Address **35.** _____ Telephone Number

36. _____ Applicant's Driver's License Number / State Identification Number **37.** _____ State Issued **38.** _____ Expiration Date

PROPOSED INSURED'S HEALTH INFORMATION

39. _____ Height / Weight **40.** _____ Doctor's Name / Street Address / Telephone Number

41. In the past 5 years, has the Proposed Insured been treated for, or been diagnosed by physician for any 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

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

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

PROPOSED INSURED'S HEALTH INFORMATION

(continued from page 1)

If you answered "Yes" to questions **41**-**43** on page 1, explain details below. Attach a separate page if additional space is needed.

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

AGREEMENT - AUTHORIZATION - ACKNOWLEDGMENT – SIGNATURES

This authorization complies with the HIPAA Privacy Rule.

I understand I can revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by giving written notice to the Polish Roman Catholic Union of America at the name and address shown above.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, MIB Inc., ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give the Polish Roman Catholic Union of America, or its representatives, including Equifax or bearer, or reinsurer, any such information. The Polish Roman Catholic Union of America may disclose such information to its reinsurer(s), MIB or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. This authorization is valid for 24 months after the date shown below. A photographic copy of this authorization shall be valid as the original.

1) AGREE that the statements and answers contained in this application are complete and true to the best of my knowledge and belief. **2) 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) 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) AGREE** that if I am not a member of the Union, this application serves as a membership application.

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison. 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.

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.

SIGNED AT _____ THIS _____ DAY OF _____, 20_____
City / State Day Month Year

_____ _____
Proposed Insured's Signature (Must be 16 Years or Older) Applicant's Signature, If Other Than Proposed Insured

_____ _____
Owner's Signature, if Other Than Proposed Insured or Applicant Sales Representative's Signature / Code or Home Office Signature

_____
Home Office Approval - HOME OFFICE USE ONLY

NOTICE OF INFORMATION PRACTICES

This Notice Must be Given to Proposed Insured

(Including MIB Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING MIB, Inc ("MIB")

Information regarding your insurability will be treated as confidential. Polish Roman Catholic Union of America, or its Reinsurer(s) may, however, make a brief report thereon to the MIB, a not-for profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of information it may have in your file by calling (866) 692-6901 or you can go to their website www.mib.com. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

POLISH ROMAN CATHOLIC UNION OF AMERICA, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

BINDING PREMIUM RECEIPT, TEMPORARY INSURANCE AGREEMENT (TIA)

The insurance provided by this receipt, subject to the provisions of the policy applied for, will become effective as of the date the fully completed application and the first (1st) premium is paid in full. The coverage for which the application is made shall be in effect until the Company or the agent has notified the applicant in writing of declination or termination of insurance coverage or an offer to insure at higher than standard rates, and returned any unearned premium. Coverage is excluded if the proposed insured commits suicide, if the application contains material misrepresentation or is fraudulently completed or if a check or draft received in payment of the premium is not honored for payment when presented. Under no circumstances will the insurance provided by this receipt, including any insurance in force or applied for with this Company, or any benefit for accidental death, exceed $ 25,000 for each person proposed for coverage.

POLISH ROMAN CATHOLIC UNION OF AMERICA
Chicago, Illinois

LIFE PLAN _____ **Amount $** _____

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE POLISH ROMAN CATHOLIC UNION OF AMERICA (PRCUA). DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

By _____ _____, 20_____
SALES REPRESENTATIVE'S SIGNATURE DATE

ADDITIONAL LIFE INSURANCE INFORMATION

Applicant:

Does the Proposed Insured currently have any existing or pending life insurance? ☐ Yes ☐ No

Is this insurance intended to replace or change any existing life insurance or annuity plan? ☐ Yes ☐ No

If "Yes", please provide company name and policy/contract number, effective date or date of issue and complete the appropriate Kansas Replacement Notice. If the existing life insurance policy or individual annuity contract has Joint Owners, both Owners must sign the Kansas Replacement Notice.

Company/ Policy Number /Effective Date:_____

_____

_____ _____
PROPOSED INSURED'S SIGNATURE (MUST BE 16 YEARS OR OLDER) APPLICANT'S SIGNATURE, IF OTHER THAN PROPOSED INSURED

Agent:

The Question below must be completed to the best of your knowledge.
Will this contract replace or use cash values of any existing life insurance or annuity with this or any other company? ☐ Yes ☐ No

If the annuity being purchased is intended to replace or use cash values of any existing life insurance or annuity with this or any other company, please complete the appropriate Kansas Replacement Notice.

If the Contract applied for replaces any existing life insurance or annuity with this or any other company, I attest that I have reviewed the potential advantages and disadvantages of the proposed transaction.

Agents Statement: I certify I have accurately recorded all information given by the Proposed Insured to the best of my knowledge. I claim full credit for this application unless other instructions are given below. I certify that this transaction is in accord with the Company's written statement with respect to the acceptability and appropriateness of replacements.

_____ _____
DATE SALES REPRESENTATIVE'S NAME

_____ _____
SALES REPRESENTATIVE'S SIGNATURE SALES REPRESENTATIVE'S CODE

_____
SALES REPRESENTATIVE'S PHONE NUMBER AND EMAIL