Ladies Pennsylvania Slovak Catholic Union - A Fraternal Benefit Society

Address: 71 South Washington Street, Wilkes-Barre, PA 18701 Phone: 888-834-6614

APPLICATION FOR LIFE INSURANCE – PART 1

1. Proposed Insured _____
(Print Name in Full)
2. Address _____
(Street)
_____
(City) (State) (Zip)

3. Telephone No. (_____)_____
4. E-mail _____

5. Social Security No. _____

6. Date of Birth_____Age _____
Place of Birth_____
Gender: ☐ Male ☐ Female

7. Applicant (if other than Insured) _____
Relationship _____ Social Security No _____
Address _____
(Street)
_____
(City) (State) (Zip)

Mail Premium Notice to: ☐ Proposed Insured ☐ Applicant

8. Plan of Insurance: _____
Amount of Insurance: $ _____
Riders: ☐ ADB $_____ ☐ Waiver of Premium
☐ Payor Death/Disability - Age of Payor _____

9. Beneficiary
(If more than one, then benefit paid equally to the survivors unless otherwise indicated. List additional beneficiaries in REMARKS)

Primary Beneficiary: Relationship to Insured
1. _____
2. _____
3. _____

Contingent Beneficiary: Relationship to Insured
1. _____
2. _ _____

10. Will the insurance being applied for replace or change insurance in this or any other company?
☐ Yes ☐ No

If Yes, give details and name of companies in REMARKS at the top of page 3.

11. Dividend Option:
☐ Paid-Up Additions ☐ Premium Reduction ☐ Cash

12. Marital Status:
☐ Single, Widowed or Divorced ☐ Married

13. Has the proposed insured ever been declined, postponed or rated up for life insurance?
☐ Yes ☐ No

14. Occupation of Insured or Applicant if insured is under 18 years of age: _____
Name of Employer_____
Address_____
(Street)
_____
(City) (State) (Zip)

15. Premiums are to be paid:
☐ Annually ☐ Semiannually ☐ Quarterly
☐ Monthly ☐ Single Premium

16. Is the Proposed Insured a member of the Society?
☐ Yes ☐ No
If not, please apply for membership.

17. Optional Secondary Addressee (for notification of a past due premium or possible lapse of coverage)
Name _____
Address _____
(Street)
_____
(City) (State) (Zip)

NOTE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PART 2 - MEDICAL INFORMATION SECTION

If a medical examination is required, this page is to be filled out by the medical examiner; if application is non-medical, this page is to be filled out by the Proposed Insured (or the Applicant).

1. IN THE PAST 10 YEARS, HAS THE PROPOSED INSURED EVER HAD OR BEEN TREATED BY A LICENSED MEMBER OF THE MEDICAL PROFESSION FOR:	**Yes**	**No**
a. Disorder of eyes, ears, nose, mouth, throat or speech?	☐	☐
b. Dizziness, fainting, seizures or convulsions, chronic headache, epilepsy, paralysis or stroke or any disease of the brain or nervous system?	☐	☐
c. Chronic cough, asthma, emphysema, tuberculosis or any lung or respiratory disorder?	☐	☐
d. Chest pain, high blood pressure, heart attack, or any disorder of the heart or blood vessels?	☐	☐
e. Hepatitis, intestinal bleeding, ulcer, colitis, diverticulitis, or any disorder or disease of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder?	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or any other disorder of the kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes, thyroid or other glandular disorder?	☐	☐
h. Sciatica, arthritis, gout, or disorder of the muscles, bones, joints, spine, back or neck?	☐	☐
i. Cancer, tumor or disorder of the lymph glands or breasts?	☐	☐
j. Allergies, anemia or other disorder of the blood?	☐	☐
2. OTHER THAN AS LISTED ABOVE, HAS THE PROPOSED INSURED, WITHIN THE LAST 5 YEARS:		
a. Had any mental or physical disorder?	☐	☐
b. Had an illness, injury or surgery?	☐	☐
c. Been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	☐
d. Been scheduled to have any test, consultation, hospitalization or surgery which was not completed (other than for AIDS or AIDS-related complex)?	☐	☐
e. Been treated for or counseled for alcohol or drug use, dependency, addiction or abuse?	☐	☐
3. Is the Proposed Insured taking any medication or drugs (legal or illegal, prescription or non-prescription) for any reason?	☐	☐
4. Has the Proposed Insured ever been diagnosed by a licensed physician as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related-Complex (ARC), HIV or any other disease of the immune system?	☐	☐
5. Does the Proposed Insured have a family history of diabetes, cancer, melanoma, heart or kidney disease, mental illness or suicide?	☐	☐
6. Has the Proposed Insured used tobacco or nicotine in any form in the last 12 months?	☐	☐

7. What is the Proposed Insured's height? _____ feet _____ inches
What is the Proposed Insured's weight? _____ lbs

If any of the above questions have been answered YES, give particulars:

_____

_____

_____

MEDICAL EXAMINER'S STATEMENT

I have completed the questions in Part 2 and the answers are true, complete and correctly recorded to the best of my knowledge and belief.

_____ _____

Signature of Medical Examiner Date Signed by Medical Examiner

REMARKS

PROPOSED INSURED/APPLICANT STATEMENT

I declare that the statements and answers given in Part 1 and Part 2 are true, complete and correctly recorded to the best of my knowledge and belief. **I understand that coverage will not be effective until the first premium has been paid and the contract has been delivered.**

I authorize the LADIES PENNSYLVANIA SLOVAK CATHOLIC UNION, its agents, employees, reinsurers, and their representatives to obtain information about the Proposed Insured to evaluate this application and to verify information in this application. This information will include: (a) age; (b) medical history, condition and care; (c) physical and mental health; (d) occupation; and (e) other insurance. This authorization extends to information on the use of alcohol, drugs and tobacco; the diagnosis or treatment of HIV (AIDS virus) infection and sexually transmitted diseases; and the diagnosis and treatment of mental illness. During the time this authorization is valid it extends to information required to determine eligibility for benefits under any policy issued as a result of this application.

I authorize any person, including any physician, health care professional, hospital, clinic, medical facility, government agency including the Veterans and Social Security Administrations, employer, consumer reporting agency, or other insurance company, to release information about the Proposed Insured to the LADIES PENNSYLVANIA SLOVAK CATHOLIC UNION or its representatives on receipt of this authorization. This information should include medical history, physical and laboratory findings (special tests, X-rays, electrocardiograms, etc.) and conclusions regarding the Proposed Insured's health. The information will be used to determine whether or not the Proposed Insured is an acceptable risk for life insurance. The LADIES PENNSYLVANIA SLOVAK CATHOLIC UNION or its representatives may release this information about the Proposed Insured to reinsurers or to another insurance company to whom the Proposed Insured has applied or to whom a claim has been made. No other release may be made except as allowed by law or as I further authorize.

This authorization is valid for 60 days from the date it is signed. A copy of this authorization is as valid as the original and will be provided on request. I may revoke this authorization at any time by writing to the LADIES PENNSYLVANIA SLOVAK CATHOLIC UNION.

Signature of Proposed Insured/Applicant	Date Signed by Proposed Insured/Applicant
Signature of Adult Applicant if Proposed Insured is under the age of 18	Date Signed by Adult Applicant
Signature of Member Applicant if Proposed Insured is not a member of the Society	Date Signed by Member Applicant

RECOMMENDER'S STATEMENT

Was this insurance applied for to replace or change any existing insurance or annuity contract? ☐ Yes ☐ No

If Yes, provide required disclosure notices to the Proposed Insured/Applicant.

Signature of Recommender	Date Signed by Recommender