

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

APPLICATION FOR LIFE INSURANCE – PART 1

If the Proposed Insured is not a member, please apply for membership.

<p>1. Proposed Insured _____ (Print Name in Full)</p> <p>2. Address _____ (Street)</p> <p>_____ (City) (State) (Zip)</p>	<p>10. Will the insurance being applied for replace or change insurance in this or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, give details and name of companies in REMARKS.</p>
<p>3. Telephone No. (_____) _____</p> <p>4. E-mail _____</p>	<p>11. Dividend Option: <input type="checkbox"/> Paid-Up Additions <input type="checkbox"/> Premium Reduction <input type="checkbox"/> Cash</p>
<p>5. Social Security No. _____</p>	<p>12. Marital Status: <input type="checkbox"/> Single, Widowed or Divorced <input type="checkbox"/> Married</p>
<p>6. Date of Birth _____ Age _____ Place of Birth _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>13. Has the proposed insured ever been declined, postponed or rated up for life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. Applicant (if other than Insured) _____ Relationship _____ Social Security No _____ Address _____ (Street) _____ (City) (State) (Zip)</p>	<p>14. Occupation _____ Name of Employer _____ Address _____ (Street) _____ (City) (State) (Zip)</p>
<p>Mail Premium Notice to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Applicant</p>	
<p>8. Plan of Insurance: _____ Amount of Insurance: \$ _____ Riders: <input type="checkbox"/> ADB: \$ _____ <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Payor Death/Disability - Age of Payor _____</p>	<p>15. Premiums are to be paid: <input type="checkbox"/> Annually <input type="checkbox"/> Semiannually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Single Premium</p>
<p>9. Beneficiary (If more than one, then benefit paid equally to the survivors unless otherwise indicated. List additional beneficiaries in REMARKS)</p> <p><u>Primary Beneficiary:</u> <u>Relationship to Insured</u></p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p><u>Contingent Beneficiary:</u> <u>Relationship to Insured</u></p> <p>1. _____</p> <p>2. _____</p>	<p>16. Proposed Insured's height? ____Ft ____In. Proposed Insured's weight? _____lbs</p>
<p>17. Optional Secondary Addressee (for notification of a past due premium or possible lapse of coverage)</p> <p>Name _____</p> <p>Address _____ (Street) _____ (City) (State) (Zip)</p>	

18. REMARKS

NOTE: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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 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.

THE LADIES PENNSYLVANIA SLOVAK CATHOLIC UNION 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 HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY.

Signature of Proposed Insured/Applicant

Date Signed by Proposed Insured/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.

The Proposed Insured/Applicant requests to be admitted to Branch # _____.

Signature of Recommender

Date Signed by Recommender

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?	<input type="checkbox"/>	<input type="checkbox"/>
b. Dizziness, fainting, seizures or convulsions, chronic headache, epilepsy, paralysis or stroke or any disease of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic cough, asthma, emphysema, tuberculosis or any lung or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Chest pain, high blood pressure, heart attack, or any disorder of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
e. Hepatitis, intestinal bleeding, ulcer, colitis, diverticulitis, or any disorder or disease of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or any other disorder of the kidney, bladder, prostate or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes, thyroid or other glandular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h. Sciatica, arthritis, gout, or disorder of the muscles, bones, joints, spine, back or neck?	<input type="checkbox"/>	<input type="checkbox"/>
i. Cancer, tumor or disorder of the lymph glands or breasts?	<input type="checkbox"/>	<input type="checkbox"/>
j. Allergies, anemia or other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
k. Alcoholism or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>

2. OTHER THAN AS LISTED ABOVE, HAS THE PROPOSED INSURED, WITHIN THE LAST 5 YEARS:

a. Had any mental or physical disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had an illness, injury or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been a patient in a hospital, clinic, sanatorium or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
d. Been scheduled to have any test, consultation, hospitalization or surgery which was not completed (other than for AIDS or AIDS-related condition)?	<input type="checkbox"/>	<input type="checkbox"/>

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, or any hereditary disease?

6. Has the Proposed Insured used tobacco or nicotine in any form in the last 12 months?

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