

# APPLICATION FOR INSURANCE

## FIRST CATHOLIC SLOVAK UNION OF THE UNITED STATES OF AMERICA AND CANADA

( A Fraternal Benefit Society )

6611 Rockside Road, Independence, Ohio 44131-2398

216-642-9406

www.fcsu.com

USE THIS FORM FOR THE FOLLOWING AMOUNTS:		
Age	Amounts Under	
0-50		\$5,001
	or	
JEP		\$25,001

Is applicant a member of the First Catholic Slovak Union? Yes( ) No( ).

If not, apply for membership. Branch \_\_\_\_\_.

E-mail Address: \_\_\_\_\_

1. Full Name (print): \_\_\_\_\_ Phone Number: \_\_\_\_\_

2. \_\_\_\_\_  
(Address) (City) (State) (Zip)

3. Birth date: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Birthplace: \_\_\_\_\_

4. Sex: M( ) F( ). Social Security No: \_\_\_\_\_ Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_

5. Occupation: \_\_\_\_\_ 6. Employer: \_\_\_\_\_

7a. Name and Address of Beneficiary: \_\_\_\_\_

\_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

7b. Name and Address of Contingent Beneficiary: \_\_\_\_\_

\_\_\_\_\_

7c. Owner, if other than proposed insured: \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

8. Is this insurance intended to replace or change any insurance or Annuity now in force? Yes( ) No( ).

If yes, give details \_\_\_\_\_

9. Within the past 5 years: has Proposed Insured used tobacco in any form? Yes( ) No( )

10a. Within the past 5 years: has Proposed Insured been hospitalized; or received medical treatment or advice for any illness, disease, injury or physical condition? Yes( ) No( ).

10b. Does Proposed Insured have any physical or mental handicaps? Yes( ) No( ).

10c. Give details of YES answers to 9, 10a, and 10b (Tobacco use; Illness or handicap; dates, duration; physicians; and/or hospital)

\_\_\_\_\_

11. Plan of Insurance: \_\_\_\_\_ Amount of Insurance: \$ \_\_\_\_\_

Rider/s: \_\_\_\_\_ Premium: \$ \_\_\_\_\_

Method of Payment: Single Premium( ). Annual( ). Semi-Annual( ). Quarterly( ).

I AGREE THAT NO INSURANCE SHALL TAKE EFFECT UNLESS AND UNTIL (1) the first premium shall have been paid; (2) a certificate is delivered to the applicant during the Proposed Insured's lifetime; (3) the health of the Proposed Insured is as described in the application; (4) the Proposed Insured has been obligated in due form; and (5) all requirements of the Constitution and Bylaws have been complied with.

Signed at \_\_\_\_\_; this \_\_\_\_\_ day of; \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Signature of Agent or Proposer

\_\_\_\_\_  
Proposed Insured's Signature (Parent or Guardian if applicant is under age 16)

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.

### AUTHORIZATION

I hereby authorize any licensed physician; medical practitioner, hospital, clinic other medical or medically related facility, insurance company, MIB, Inc ("MIB") or other organization, institution or person that has any record or knowledge of me or my health, to give to First Catholic Slovak Union or its representatives, or bearer, or its reinsurers any such information. Authorization is valid for no longer than thirty months. A photographic copy of this authorization shall be as valid as the original.

Date \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Signature of Agent or Proposer.

\_\_\_\_\_  
Proposed Insured's Signature (Parent or Guardian if applicant is under age 16).