

APPLICATION FOR INSURANCE

Part One of Application
 PLEASE PRINT



**FIRST CATHOLIC SLOVAK UNION
of the USA and Canada**
 6611 ROCKSIDE ROAD SUITE 300, INDEPENDENCE, OHIO 44131

• *A Fraternal Benefit Society* •

INSURANCE FRAUD WARNING

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.

A. IDENTIFICATION OF PROPOSED INSURED

Is applicant a member of the First Catholic Slovak Union? Yes No. If not, apply for membership.

The undersigned hereby requests the First Catholic Slovak Union to admit the herein named as a member in:

Senior Branch _____ at _____

City _____ State _____

1a. Full Name of Proposed Insured: _____ 1b. Phone number: _____ 1c. Social Security No.: _____

2. Address: _____ Street _____ City _____ State _____ Zip Code _____

3a. Birthdate: (Month, Day, Year) _____ b. Age: _____ c. Birthplace: _____ d. E-mail Address _____ 4. Male Female

5. Name of Employer: _____ 6. Address: _____

7. Occupation: _____ b. How long employed: _____ Years _____ Months _____

c. Describe duties: _____

B. THE INSURANCE

1. Basic Plan: 20 Year Pay Life Annual Renewable Term 10 Year Level Term 20 Year Level Term or Other Plan Single Premium Whole Life Ordinary Life Term to Age 25

2. Amount of insurance: \$ _____

3. Riders w/this Plan: _____ Amount: _____

a. Accidental Death Benefit \$ _____

b. Payor/Waiver of Premium \$ _____

c. Flexible Premium Annuity Rider: Initial Premium \$ _____ Benefits Commence at age _____

d. Other: _____ Amount: _____

4. Premiums to be paid: Monthly Quarterly Semi-Annually Annually

5. Dividend election: Cash Left at Interest Paid up Additions Reduce Premium

[If left at interest option selected; must have Social Security No. (1b)]

6. Beneficiary. Will receive proceeds unless changed by the Owner. **[List full name, relationship, and birthdate.]**

NAME	RELATIONSHIP	BIRTHDATE	AMOUNT
			\$
			\$

7. Contingent Beneficiary. If any: **[list full name and address.]**

C. INSURABILITY

1. Has proposed Insured ever had any disease or disorder of: _____ **[If yes, circle condition and give details in No. 4]**

2. Has proposed Insured ever had any symptoms of or been affected with: _____

a. Nervous system, epilepsy, or paralysis? <input type="checkbox"/> Yes <input type="checkbox"/> No.	a. Cancer, tumor; diabetes, glands; or blood disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No.
b. The heart or blood vessels; chest pains; high or low blood pressure, rheumatic fever? <input type="checkbox"/> Yes <input type="checkbox"/> No.	b. Any serious illness, disease or injury not already listed? <input type="checkbox"/> Yes <input type="checkbox"/> No.
c. Stomach, liver, intestines, gall bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No.	c. Consultation, treatment or been examined by a physician or other practitioner for any other reason? <input type="checkbox"/> Yes <input type="checkbox"/> No.
d. The kidney, urinary, bladder, prostate? <input type="checkbox"/> Yes <input type="checkbox"/> No.	
e. Lungs; asthma, tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No.	

3. Height and weight of proposed Insured: _____ ft. _____ in.; _____ lbs.

4. Give complete details of any "YES" answers to Questions C1 and 2. Give the full name and addresses of physicians seen or hospitals used within the last 5 years. Include dates, nature of disease or injury and treatment.

5a. Family Record	Living		Dead	
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers/Sisters				

5b. Have any of your parents, brothers, or sisters ever had heart disease, diabetes, or mental illness? Yes No. If yes, explain: _____

6. In the past 5 years, have you used: _____ Details of Yes Answer: _____

a. alcoholic beverages? Yes No.

b. narcotics or drugs? Yes No.

PREMIUM CALCULATION [Home Office use]

7. In the past 10 years, have you been treated for alcoholism or any drug habit? Yes No. If yes, explain: _____

8. In the past 10 years have you been in a hospital, clinic, sanatorium, or institution for examination, observations, diagnosis, operation, or treatment?
 Yes No. If yes, explain: _____

8a. Have you used tobacco? If yes, explain: _____

9a. Are you now a cigarette smoker? Yes No. If yes, explain: _____

b. Have you been a smoker and quit? Yes No.

c. Did you quit within the past 6 months? Yes No.

6 months to 1 year ago? Yes No.

more than 1 year ago? Yes No.

d. Did, or do, you smoke more than one pack daily? Yes No.

10. Amount of life insurance in force on life of proposed Insured: Other companies? _____ with F.C.S.U.? _____

11. Has proposed Insured had life or health insurance rejected; rated up; postponed; modified; cancelled or not renewed? Yes No.

If yes, explain: When? _____ What Company? _____

D. OTHER ITEMS

1. Has proposed Insured ever engaged in or intend engaging in any type of flying as pilot or crew member, skin or sky diving, racing, or other hazardous activities?
 Yes No. If yes, give details: _____

2. Name of owner of this policy, if other than proposed Insured? _____ Relationship? _____

3. Will insurance applied for replace or change any insurance or annuities? Yes No.
Company? _____ Amount? _____

4. Do you as applicant declare on behalf of yourself and any person who shall have an interest in any contract issued hereunder, that you have read each of the above answers and that to the best of your knowledge and belief they are full, complete and true? Answer: _____

5. Do you as applicant agree that the acceptance of the contract with copy of this application attached constitutes ratification by applicant of corrections and additions by the Society in space below except there can be no change of amount, classification, age at issue, kind or plan of insurance or benefits, unless agreed to in writing?
Answer: _____

E. JUVENILE SECTION. Answer following questions only for life insurance on child under age 15 (complete ownership question D2)

1. Applicant's Name: _____	2. Relationship _____
3. Address [if different from No. A2.] _____	4. Total amount of Life Insurance in force on the Applicant: \$ _____
5. Applicant's Birthday: (Mo., Day, Yr.) Age: _____ Birthplace: _____	6. Occupation: _____

7. Had child any birth injury or do you know of any congenital or hereditary abnormality or disease which may affect the child's future health?
 Yes No. If yes, give details: _____

I agree that no insurance shall take effect unless and until: (1) application has been approved by the underwriter and the first premium shall have been paid; (2) a contract 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.

Dated this _____ day of _____ 20 _____ at _____

Officer or Recommender

Address _____
Officer or Recommender

Home Office _____
(date)

Signature of Proposed Insured
[Parent or Guardian if applicant is under age 16]

City _____ State _____ Zip Code _____

Approved by _____
Executive Secretary

Notice to Proposed Insured

I understand that information regarding my insurability will be treated as confidential. First Catholic Slovak Union or its reinsurer may however, make a brief report thereon to the MIB, Inc, formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. Should I apply to another MIB member company for life or health insurance coverage, or if a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about me in its files.

Upon receipt of a request from me, MIB will arrange disclosure of any information in my file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). Should I question the accuracy of the information in MIB's file, I 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's information office [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

First Catholic Slovak Union, or its reinsurer, may also release information from its file to other insurance companies to whom I may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Authorizations

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 _____

Witnessed by Officer or Recommender

Signature of Proposed Insured
[Parent or Guardian, if applicant is under age 16.]

CERTIFICATE OF THE SOCIETY OFFICERS

We certify that the applicant herein named was accepted to membership on the _____ day of _____ 20 _____

President of Branch

Branch Officer