

# APPLICATION FOR INSURANCE



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

• A Fraternal Benefit Society •

Part One of Application  
PLEASE PRINT

**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 \_\_\_\_\_; or Junior Branch \_\_\_\_\_; at \_\_\_\_\_  
 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

1a. Full Name of Proposed Insured: 1b. Social Security No.:

2. Address: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

3a. Birthdate: (Month, Day, Year) \_\_\_\_\_ b. Age: \_\_\_\_\_ c. Birthplace: \_\_\_\_\_ 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  5 Year Renewable Term  Single Premium Whole Life  or Other Class \_\_\_\_\_  
 Ordinary Life  Term to Age 25

2. Amount of insurance: \$ \_\_\_\_\_

3. Riders w/this Plan:  
 a.  Children's Protection \$ \_\_\_\_\_ Amount: \_\_\_\_\_  
 b.  Spouse Protection \$ \_\_\_\_\_  
**[Complete Appl. S/C-11]**  
 c.  Decreasing Term 20, 25, 30, Yr. \$ \_\_\_\_\_  
**[Circle No. Years. Complete additional Appl. AJ-2]**  
 d.  Accidental Death Benefit \$ \_\_\_\_\_

e.  Payor/Waiver of Premium  
 f.  Flexible Premium Annuity Rider:  
 Initial Premium \$ \_\_\_\_\_  
 Benefits Commence at Age \_\_\_\_\_  
 g.  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]**

1. Has proposed Insured ever had any disease or disorder of:	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:  
 a. alcoholic beverages?  Yes  No. Details of Yes Answer: \_\_\_\_\_  
 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: \_\_\_\_\_

- 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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

Address \_\_\_\_\_  
Officer or Recommender

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Office \_\_\_\_\_  
(date)

Approved by \_\_\_\_\_  
Executive Secretary

**NOTICE TO PROPOSED INSURED**

I understand that information regarding my insurability will be treated as confidential. The First Catholic Slovak Union may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates as information exchange in behalf of its members. Should I apply to another Bureau member company for life or health insurance coverage, or if a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its files.

Upon receipt of a request from me, the Bureau will arrange disclosure of any information it may have in my file. (Medical Information will be disclosed only to my attending physician.) Should I have a question regarding the accuracy of information in the Bureau's file, I may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

The First Catholic Slovak Union may also release information in its file to the other life insurance companies to whom I may apply for life or health insurance, or to whom a claim for benefits may be submitted.

I further understand that in connection with this application for insurance an investigative consumer report may be made as to my insurability, whereby information may be obtained through interviews with neighbors, friends and associates, and which may include, if applicable, information to character, general reputation, personal characteristics and mode of living. Additional detailed information as to the nature and scope of any investigation will be furnished upon written request.

**AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health to give to First Catholic Slovak Union or its representatives, including Equifax, or bearer, or reinsurer, any such information.

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