APPLICATION FOR INDIVIDUAL LIFE 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 knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Certificate # _____

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 _____ City _____ State _____

1a. Full Name of Proposed Insured (Complete in all cases. This person will also be the Policy Owner, unless the Owner section is completed below.) _____ 1b. Phone _____ 1 c. Social Security # _____

2. Address Street _____ City _____ State _____ Zip _____

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

4. Sex ☐ Male ☐ Female

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

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

7c. Describe Duties: _____

B. OWNER (Complete in all cases for Proposed Insured 17 years of age and under; for adults only if other than the Proposed Insured above.)

1. Full Name of Individual/Entity* _____ 2. DOB (Month, Day, Year) _____

3. Address Street _____ City _____ State _____ Zip _____ 4. Phone _____

Social Security/Tax ID # _____ Relationship _____ *If an Entity, name a contact person _____ Phone _____

C. THE INSURANCE

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

2. Amount of Insurance: $ _____

3. Riders w/this Plan — Amount
a. ☐ Accidental Death Benefit $ _____
b. ☐ Payor/Waiver of Premium $ _____
c. ☐ Other _____ $ _____

4. Include Automatic Premium Loan (If applicable)? ☐ Yes ☐ No

5. Premiums to be paid: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Single

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

If left at interest option selected; must have Social Security No. (1c) _____

D. BENEFICIARY (To name additional Primary and Contingent Beneficiaries, sign, date and list names on a separate sheet of paper)

1. **Primary Beneficiary**. Will receive proceeds unless changed by the Owner.

NAME	ADDRESS	SOCIAL SECURITY #	PHONE	RELATIONSHIP	SHARE

2. **Contingent Beneficiary**

3. **Trust as Beneficiary** (Complete Verification of Trust Form if section b is completed below) Primary ☐ Contingent ☐
   a. Trust under the Insured's last will. ☐ ☐
   b. Trust Name: _____ Trust Dated: _____ ☐ ☐

E. GENERAL INFORMATION

1. Foreign Travel, Aviation, and Military
   a. Does any person to be covered intend to travel outside the U.S. or Canada within two years? ☐ Yes ☐ No
   b. Except as a passenger on a regularly scheduled flight, does any person to be covered intend to fly or has he/she flown during the past two years? ☐ Yes ☐ No
   c. Is any person to be covered a member, or does he/she intend to become a member of the Armed Forces (including Reserves and National Guard)? ☐ Yes ☐ No
2. Avocation and Sports
   In the past three years, has any person to be covered participated in any form of racing, skin or scuba diving, parachuting, hang gliding, rock climbing or any similar sport or avocation? ☐ Yes ☐ No

   Remarks: Give details for any question answered "Yes" Identify the person affected: _____

3. Driving Information
   a. Driver's License Proposed Insured's # _____ State _____
   b. Has any Proposed Insured been convicted with any moving violation or accident at fault within the last 5 years? ☐ Yes ☐ No
4. Annual Income Information Proposed Insured $ _____ Other/Spouse $ _____
5. a. Does any person to be covered have existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☐ No
   b. Has any company declined to issue, renew, or reinstate: rated, modified, postponed or cancelled any life or health insurance on any person covered? ☐ Yes ☐ No
   c. Will insurance applied for replace or change any insurance or annuities? ☐ Yes ☐ No
      If yes, Name of Company: _____ Policy # _____ Amount: $ _____
   d. Is any application for life or health insurance on any person to be covered pending in any other company? ☐ Yes ☐ No

F. MEDICAL INFORMATION

1. Personal Measurements: **Height** _____ **ft.** _____ **in.** **Weight** _____ **lbs.**
2. **During the past five years**, has any person to be covered been examined or prescribed medication by a physician or a member of the medical profession? ☐ Yes ☐ No
3. Has any person to be covered **ever** been treated for, or been diagnosed by a physician as having:
   a. Cancer, diabetes, or high blood pressure? ☐ Yes ☐ No
   b. Disease or disorder of the heart or blood ☐ Yes ☐ No
   c. Nervous or mental condition, or any disease or abnormality of the brain or nervous system? ☐ Yes ☐ No
   d. Any disease or abnormality of the lungs or respiratory system? ☐ Yes ☐ No
   e. Disease or abnormality of the kidneys, liver, prostrate or genitourinary system? ☐ Yes ☐ No
   f. Disease or abnormality of the gastrointestinal system? ☐ Yes ☐ No
   g. Disorder of the muscles, bones, or joints? ☐ Yes ☐ No
4. Has any person to be covered **ever** been advised to seek treatment or counseling, been treated for or received counseling, or joined a support group for the use of alcohol? ☐ Yes ☐ No
5. Has any person to be covered **ever** been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
6. During the last 5 years has any person to be covered been hospitalized or had surgery of any kind? ☐ Yes ☐ No

F. MEDICAL INFORMATION (Continued)

7. Has any person to be covered:
   a. Other than a one-time or experimental basis, used barbiturates, heroin, cocaine, marijuana, or any illegal, restricted or controlled substance, except as prescribed by a physician? ☐ Yes ☐ No
   b. Been advised to seek, or received medical treatment for drug use, or been convicted for drug use or pled guilty to charge of drug use or distribution? ☐ Yes ☐ No
8. Has any person to be covered used any nicotine products (cigarettes, cigars, chewing tobacco, pipe, nicotine gum, patch or other)?
   a. In the past 12 months ☐ Yes ☐ No
   b. In the past 36 months ☐ Yes ☐ No
   (If yes, indicate the name of the person and list all products used) _____
9. Is any person to be covered pregnant? If yes, indicated anticipated date of delivery. ☐ Yes ☐ No
10. Is any medication currently prescribed for any person to be covered? If yes, name them and for whom they are prescribed. ☐ Yes ☐ No
11. Has any person to be covered had a parent or sibling:
   a. Diagnosed or treated by a member of the medical profession with cardiovascular disease, stroke, or cancer prior to age 60? ☐ Yes ☐ No
   b. Die from cardiovascular disease below age 60? ☐ Yes ☐ No

Give Details for all "Yes" answers.

Question #	Dates	Medical Condition	Name of Doctor

(Please place additional information on a separate sheet)

Physician Information

Name of Doctor	Address	Phone Number

G. OTHER ITEMS

3. 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: _____

4. Do you as applicant agree that the acceptance of the contract with copy of this application attached constitutes ratification by applicant or 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: _____

H. JUVENILE SECTION. Answer following questions only for life insurance on child under age 17 (complete ownership Section B)

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. AGREEMENT-AUTHORIZATION-ACKNOWLEDGMENT

This authorization complies with the HIPAA Privacy Rule.

I understand I may revoke this authorization at any time, except to the extent that action has been take in reliance on this authorization, by sending written notice to the Life Underwriting Department of First Catholic Slovak Union of the USA and Canada.

I, the Primary Proposed Insured (and any Spouse or Owner signing below), by my signature set forth hereafter: **AGREE** to the following:

a) All Statements and answers in this application are complete and true to the best of my knowledge and belief
b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is delivered while the health of any proposed insured continues, without material change, to be as represented in this application.
c) No agent has the authority to waive any answer or otherwise modify this application or to bind First Catholic Slovak Union of the USA and Canada, hereinafter called "Society", in any way by making any promise or representation which is not set out in writing in this application.
d) $ _____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted.

Signed at _____ this _____ day of _____ 20 _____

Proposed Insured (Age 18 or older)

Owner, if other than Proposed Insured

Witness (Licensed Agent and Number where required)

Adult and/or Member Applicant

Approved by _____
Executive Secretary

AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy benefits, manager, insurance support organization, pharmacy/government agency, insurance or reinsuring company, MIB, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person to give to the Society or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which related to the physical and mental conditions of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorized the Society, or its reinsurers, to release any information including my personal health information obtained to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for the maximum length of time permitted by applicable law in the state where the policy/certificate is delivered or issued for delivery. I know that I or my representative may request a copy of this authorization.

It is understood that First Catholic Slovak Union of the USA and Canada underwriters, claim examiners, reinsurers, attorneys or the medical director may disclose such health information to the parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed the recipient may re-disclose it resulting in loss of protections by federal regulations. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my states so provides, my authorization may not be revoked suing a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Society, or its reinsurer, (or the Society or its reinsurers, becomes obligated to report such codes to MIB) while this authorization is in force. I may refuse to sign this authorization and that my refusal will affect my ability to obtain life insurance coverage.

Date _____ , 20 _____

Agent

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

J. AGENT'S STATEMENT

To the best of your knowledge and belief, will the insurance applied for replace or change any existing insurance or annuity? ☐ Yes ☐ No
If yes, any replacement regulations must be complied with.

Notice to Proposed Insured

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING MIB, Inc, ("MIB")
Information regarding your insurability will be treated as confidential. First Catholic Slovak Union of the USA and Canada, or its Reinsurer(s) may, however, make a brief report thereon to the MIB, a non-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, MIB will arrange disclosure of and information it may have in your file by calling (866) 692-6901 or you can go to their website www.mib.com. If you question the accuracy of information in MIB's file, you 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 is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184].

First Catholic Slovak Union of the USA and Canada, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.