First Catholic Slovak Union of the USA and Canada

A Fraternal Benefit Society

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

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

Branch #: _____ Certificate #: _____

1. Proposed Insured: ☐ Male ☐ Female Height _____ Weight _____ Email: _____

Full Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____ Occupation: _____

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

2. Owner: (Complete if Owner is other than Proposed Insured or in all cases for Proposed Insured under age 17 years)

Full Name: _____ Phone Number: _____

Address: _____ City _____ State: _____ Zip: _____

Social Security #: _____ Relationship: _____

3. Plan: _____ Face Amount: $ _____ Payment: $ _____

Premium Mode: ☐ Single ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Dividend Election: ☐ Cash ☐ Reduce Premium ☐ Accumulate at Interest ☐ Paid-Up Additions

Riders: ☐ Accidental Death Benefit; Amount: $ _____ ☐ Waiver of Premium _____

☐ Term, Plan: _____ Benefit Amount: $ _____ ☐ Other: _____

Will the insurance applied for replace or change any existing insurance or annuity? ☐ No ☐ Yes If Yes, Show the name of

Company and Policy Number(s): _____

4. Beneficiary:

Full Name: _____ Date of Birth _____

Address _____

Social Security #: _____ Relationship: _____ Share: _____

Full Name: _____ Date of Birth _____

Address _____

Social Security # _____ Relationship: _____ Share: _____

Contingent:

Full Name: _____ Date of Birth _____

Address _____

Social Security # _____ Relationship: _____ Share: _____

If there are additional beneficiaries, list on a separate sheet of paper.

5. In the past 2 Years, has the Proposed Insured:	Yes	No
a. used tobacco in any form?	☐	☐
b. flown as the pilot or crew member of any form of aircraft, or intend to do so?	☐	☐
c. had any license to drive suspended or revoked?	☐	☐

Detail any *Yes* answer _____

6. Health Questions:

a. In the past 5 years, has the Proposed Insured received diagnosis or treatment from a physician; or been confined in a medical care facility?
☐ No ☐ Yes (If Yes, circle any applicable condition; provide details in item C below.)

(1) cancer; tumor or malignancy; diabetes; heart or circulatory disease or disorder; high blood pressure; kidney or genito-urinary disease or disorder; lung or respiratory disease or disorder; epilepsy; mental or nervous disease or disorder; stroke; use of alcohol or non- prescription drugs; any disease or disorder of the stomach; intestines; gall bladder; liver; or rectum? ☐ No ☐ Yes

(2) any deformity, disease or disorder not listed above or any surgical operation scheduled or contemplated? ☐ No ☐ Yes

b. Has a member of the medical profession ever diagnosed any person to be covered as having; or treated any applicant for AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex)? ☐ No ☐ Yes

c. Details: Any *Yes* answer in question a or b above. Show: condition; dates; name(s) and address(es) of physician(s) and medical care facilities. ☐ No ☐ Yes

_____

_____

_____

d. Family Doctor: Name: Address: Phone:

_____

7. 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.

Each person signing this application; (1) REPRESENTS that, to the best of such person's knowledge and belief, all statements and answers included herein are complete, true and accurately recorded; (2) AGREES that this application shall be the basis for, and part of, any life insurance certificate issued; and (3) UNDERSTANDS that no agent or person, other than the President or Secretary of the Society, may, in writing: (a) change, modify or waive any of the printed statements herein; or (b) waive any of the rights or requirements of the Society.

Except as may be provided in a Conditional Receipt, bearing the same date and Payment as shown in this application, no insurance will take effect unless and until: (1) this application is approved by the First Catholic Slovak Union of the USA and Canada; (2) a certificate of life insurance is issued; and (3) the full first premium is paid. All such conditions must be met while the health and other factors affecting the insurability of the Proposed Insured remain as described in this application.

AUTHORIZATION The undersigned hereby authorizes any of the following, who may have any records or information regarding the Proposed Insured: physician or medical practitioner; medical care facility; the MIB; insurer; employer; institution; organization; or person to provide such records or information to the Union and its reinsurer; or, except for the MIB, its legal representative. I authorize the Union or its reinsurer to make a brief report to the MIB; other insurers in which the Proposed Insured may have insurance; or to whom the Proposed Insured may apply for insurance; or to whom a claim may be submitted; or as may be lawfully required. Any records or information obtained will be treated as confidential and be used to determine eligibility for insurance or benefits.

On request, the Union will provide a copy of this Authorization. This Authorization shall be valid for a period of 24 months from the date shown below. This authorization may be revoked, by written notice, at any time prior to its expiry. A photocopy shall be valid as the original.

FIRST CATHOLIC SLOVAK UNION OF THE USA AND CANADA IS LICENSED TO DO BUSINESS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN ANY STATE'S 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.

I 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

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