

# Application for Life Insurance

**Slovak Catholic Sokol**

*A Fraternal Benefit Society*

Office Use Only: Assembly/Wreath \_\_\_\_\_

**PART I - PROPOSED INSURED** Is the Proposed Insured a member of Slovak Catholic Sokol?  Yes  No. If not, applying for membership.

Full Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_

Email Address: \_\_\_\_\_  Male  Female

*Optional Secondary Addressee:* Name \_\_\_\_\_

*(Notification of Past Due Premium)* Address \_\_\_\_\_

**Owner** (If other than the Proposed Insured.)  Check if owner is to remain after insured attains age 18

Full Name of Individual/Entity \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Social Security/Tax ID#: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Insurance Coverage** Face Amount \$ \_\_\_\_\_

Base Coverage:  Single Premium Life  3 Payment Life  10 Payment Life  20 Payment Life  
 Whole Life  5 Year Term  Juvenile Term to Age 25  Other \_\_\_\_\_

Riders/Benefits: Face Amount \$ \_\_\_\_\_  
 Accidental Death Benefit  Waiver of Premium  Payor Waiver of Premium, Age of Payor \_\_\_\_  Term Rider

Premium Mode Frequency:  Annual  Semi-Annual  Quarterly  Monthly (EFT Authorization)  Single

Automatic Premium Loan Option:  Yes  No

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

## Existing Insurance

List the life insurance and annuities in force on the Proposed Insured:

<u>Company</u>	<u>Year Issued</u>	<u>Plan</u>	<u>Amount</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Will the insurance applied for replace or change any existing life insurance or annuity contracts?  Yes  No. If yes, show the name of Company and Policy Number(s), add an additional sheet of paper, if necessary:

**Beneficiary** (To name additional Primary and Contingent Beneficiaries, sign, date and list names on separate sheet of paper)

Primary: Full Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_

Contingent: Full Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_

**PART II - INSURABILITY**

Height: \_\_\_\_ ft \_\_\_\_ in. Weight \_\_\_\_\_ lbs.

A. In the past 2 years, has the Proposed Insured:

- 1. Used tobacco in any form?
- 2. Flown as the pilot or crew member of any form of aircraft, or intend to do so?
- 3. Had any license to drive suspended or revoked?

<b>YES</b>	<b>NO</b>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Details any Yes answer: \_\_\_\_\_

(Add an additional sheet of paper, if necessary)

B. In the past 5 years, has the Proposed Insured: received diagnosis or treatment from a physician; or, been confined in a medical care facility, for: (Circle any applicable condition.)

- 1. cancer, tumor or malignancy; diabetes; heart or circulatory disease or disorder; high blood pressure; kidney or genitourinary disease or disorder; lung or respiratory disease or disorder; epilepsy or 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.

C. Has Proposed Insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related-Complex (ARC)?  No.  Yes.

D. Has the Proposed Insured gained or lost weight in the Past Year?  No.  Yes.

E. Give details for any Yes answer above. Show: condition; dates: and name(s) and address (es) of physician(s) and medical care facilities. If additional space is needed, use a separate sheet, dated and signed.

**Fraud Warning**

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

**Insured/Applicant Statement**

I declare that the statement and answers given in Part I and Part II are true, complete and correctly recorded to the best of my knowledge and belief. **I understand that coverage will not be effective until the first premium has been paid and the contract has been delivered.**

I authorize the Slovak Catholic Sokol, its agents, employees, reinsurers, and their representatives to obtain information about the Insured to evaluate this application and to verify information in this application. This information will include: (a) age; (b) medical history, condition and care; (c) physical and mental health; (d) occupation; and (e) other insurance. This authorization extends to information on the use of tobacco; the diagnosis or treatment of the AIDS virus (excluding HIV) and sexually transmitted diseases; and the diagnosis and treatment of mental illness. During the time this authorization is valid it extends to information required to determine eligibility for benefits under any policy issued as a result of this application.

I authorize any person, including any physician, health care professional, hospital, clinic, medical facility, government agency including the Veterans and Social Secretary Administrations, employer, or other insurance company, to release information about the Proposed Insured to the Slovak Catholic Sokol or its representatives on receipt of this authorization. This information should include medical history, physical and laboratory findings (special tests, X-rays, electrocardiograms, etc.) and conclusions regarding the Proposed Insured's health. This authorization specifically excludes psychotherapy notes and HIV test results. The information will be used to determine whether or not the Proposed Insured is an acceptable risk for life insurance. The Slovak Catholic Sokol or its representatives may release this information about the Proposed Insured to reinsurers or to another insurance company to whom the Insured has applied or to whom a claim has been made. No other release may be made except as allowed by law or as I further authorize.

This Authorization is valid for 24 months from the date it is signed. A copy of this authorization is as valid as the original and will be provided on request. I may revoke this authorization at any time by writing to the Slovak Catholic Sokol.

Signed at \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_\_

Proposed Insured (Age 18 or older)	Owner, if other than Proposed Insured	Adult and/or Member Applicant
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**Agent's Statement:** Does the Proposed Insured have any existing life insurance or annuities?  No.  Yes.  
To the best of your knowledge and belief, will the insurance applied for replace or change any existing insurance or annuity?  
 No.  Yes. If the answer to either question is Yes, then any replacement regulations must be complied with.

Witness (Licensed Agent and Number)	Date
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