

# Slovak Catholic Sokol A Fraternal Benefit Society

205 Madison Street, Passaic, NJ 07055

Phone (800) 886-7656 • Fax (973) 779-8245 • (973) 777-2605 • Web Site: [www.slovakcatholicsokol.org](http://www.slovakcatholicsokol.org)

## Application for Life Insurance

**Membership:** Is the Proposed Insured a member of the Slovak Catholic Sokol?  Yes.  No. If not, applying for membership.

**Proposed Insured:** (Complete in all cases. This person will be the Policy Owner, unless the Owner section is completed.)

Full Name \_\_\_\_\_ Email Address: \_\_\_\_\_

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

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long at this Occupation? \_\_\_\_\_

Employer's Address/Phone \_\_\_\_\_

*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 \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security/Tax ID#: \_\_\_\_\_ Relationship \_\_\_\_\_

\*If an Entity, name a Contact Person \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If Payor of insurance is other than the Owner, complete the following information: Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Full Name \_\_\_\_\_ Relationship \_\_\_\_\_

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

**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
-----------------------	-------------------	--------------	-------

_____	_____ - _____ - _____	_____	_____
-------	-----------------------	-------	-------

_____	_____ - _____ - _____	_____	_____
-------	-----------------------	-------	-------

_____	_____ - _____ - _____	_____	_____
-------	-----------------------	-------	-------

**Trust as Beneficiary:** (complete Verification of Trust Form if section b is completed below)

a) Trust under the Insured's last will. Primary  Contingent

b) Trust Name \_\_\_\_\_ Trust Dated \_\_\_\_\_ as amended Primary  Contingent



## Personal Measurements:

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

## Medical Information:

- 1) **During the past seven years**, has Proposed Insured been examined or prescribed medication by a physician or medical practitioner?  Yes  No
- 2) Has Proposed Insured in the last ten (10) years **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, prostate 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
- 3) Has Proposed Insured **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
- 4) Has member of the medical profession **ever** diagnosed Proposed Insured as having, or treated any applicant for AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex)?  Yes  No
- 5) During the last 5 years has Proposed Insured been hospitalized or had surgery of any kind?  Yes  No
- 6) 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 treatment for drug use, or been convicted for drug use or distribution?  Yes  No
- 7) Has Proposed Insured 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)
- 8) Is Proposed Insured pregnant or expect to become pregnant within nine months?  Yes  No  
(If yes, indicate anticipated date of delivery)
- 9) Is any medication currently prescribed for any person to be covered? If "Yes", name them and for whom they are prescribed.  Yes  No
- 10) Has Proposed Insured had a parent or sibling:
  - a) Diagnosed 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.

Quest#	Dates	Medical Condition	Name of Doctor

(Please place additional Information on a separate sheet)

## Physician Information

Name of Doctor	Address	Phone Number
		(     )     -
		(     )     -

## Fraud Warning

### New Jersey

Any person who includes any false or misleading information on an application for any insurance policy is subject to criminal and civil penalties.

### 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.

### Pennsylvania

Any person who knowing and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

## 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 Security Administrations, the Medical Information Bureau (MIB), 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

**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 where required)

\_\_\_\_\_  
Date

For Home Office Use: Assembly/Wreath # \_\_\_\_\_ Certificate # \_\_\_\_\_