Application for Life Insurance

Slovak Catholic Sokol

A Fraternal Benefit Society

PART I - PROPOSED INSURED: Is the Applicant a member of Slovak Catholic Sokol? ☐ Yes. ☐ No.
If not, applying for membership. The undersigned hereby requests the Slovak Catholic Sokol to admit the herein named as a member in: Assembly/Wreath _____ City _____ State _____ ☐ Male ☐ Female

Full Name _____ Phone # (_____) _____-_____

Address_____City_____ State_NY_ Zip Code _____

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

Owner: (Complete in all cases for Proposed Insured 18 years of age and under; or if other than the Proposed Insured)

Full Name of Individual_____Date of Birth _____

Address _____ Social Security/Tax ID#:_____

City_____ State_NY_ Zip Code _____ Phone # (_____) _____-_____

Insurance Coverage: Face Amount $_____ 1035 Exchange $_____

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 ☐ Term Rider

☐ Payor Waiver of Premium: Name of Payor_____ Payor Date of Birth _____
Address of Payor_____

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

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

Is the Insurance applied for intended to replace or change any existing insurance or annuity contracts? ☐ Yes ☐ No. If yes, show the name of Company and Policy Number(s):

_____

_____

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:	**YES**	**NO**
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?	☐	☐

Details any Yes answer: _____

_____

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 genito-urinary 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 the Proposed Insured ever been diagnosed or treated by a member of the medical profession 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.)

F. Are you currently taking any prescription medications? ☐ No. ☐ Yes. If yes list condition, name of medication and dosage.

_____

_____

G. Existing Insurance on Proposed Insured (and Applicant if Insured is less than 15 ½):

Company or Society	Amount	Plan	Year Issued

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.** This application form will be attached to and made part of the insurance contract.

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. It excludes information pertaining to the treatment for use of drugs or alcohol. 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 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 Insured's health. This authorization specifically excludes psychotherapy notes and information pertaining to the treatment for use of drugs or alcohol.. The information will be used to determine whether or not the Insured is an acceptable risk for life insurance. The Slovak Catholic Sokol or its representatives may release this information about the 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 _____, 20 ____

_____ _____
Proposed Insured (Age 14 ½ or older) Owner, if other than Proposed Insured

_____ # _____ _____
Witness (Licensed Agent and Number) 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.