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

Base Coverage: Plan Name _____ Face Amount $_____

Riders/Benefits: Face Amount $_____ ☐ Term Rider _____

☐ Accidental Death Benefit ☐ Waiver of Premium ☐ Payor Waiver of Premium, Age of Payor ____

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:

Company	Year Issued	Plan	Amount

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:	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: _____

(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 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 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

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

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 Slovak Catholic Sokol; (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 Medical Information Bureau (MIB); insurer; employer; institution; organization; or person to provide such records or information to: the Slovak Catholic Sokol and its reinsurer; or, except for the MIB, its legal representative. The Slovak Catholic Sokol or its reinsurer may release any such records or information: 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 Slovak Catholic Sokol will provide a copy of this Authorization. The time limit of this authorization shall comply with the time limit of thirty months, This authorization may be revoked, by written notice, at any time prior to its expiry. A photocopy shall be valid as the original. The insured/Applicantl or authorized representative is entitled to receive a copy of the authorization form.

SLOVAK CATHOLIC SOKOL 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.

Signed at_____ this _____ day of _____, 20_____

_____	_____	_____
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