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**

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)

	Primary	Contingent
a) Trust under the Insured's last will.	☐	☐
b) Trust Name_____ Trust Dated _____ as amended	☐	☐

Coverage Information:

Base Coverage: **Face**
Plan Name _____ **Amount $**_____

Premium Received

$_____ **Code** _____
$_____**Term Policy Fee**

$_____ **Code** _____
$_____ **Code** _____
$_____ **Code** _____
$_____ **Code** _____

$_____ **Total**

Riders/Benefits

☐ **Waiver of Premium**
☐ **Accidental Death Benefit Amount $**_____
☐ **Payor Waiver of Premium, Age of Payor** _____
☐ **Other Amount $**_____

Include Automatic Premium Loan? ☐ Yes ☐ No

Premium Mode Information

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (Complete EFT Authorization) ☐ Single

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

Do you have an existing life insurance or annuity certificates? ☐ **Yes.** ☐ **No.**
If yes, is it intended to replace the existing policies? ☐ **Yes.** ☐ **No. If yes, complete the Replacement of Life Insurance and Annuities Form.**

General Information:

1) Foreign Travel, Aviation, and Military

a) Does Proposed Insured intend to travel outside the U.S. or Canada within two years? ☐ Yes ☐ No
b) Except as a passenger on a regularly scheduled flight, does Proposed Insured intend to fly or has he/she flown during the past two years? ☐ Yes ☐ No
c) Is Proposed Insured a member, or does he/she intend to become a member of the Armed Forces (including Reserves and National Guard within the next two years)? ☐ Yes ☐ No

2) Avocation and Sports

In the past three years, has Proposed Insured participated in any form of racing, skin or scuba diving, parachuting, hang gliding, rock climbing or any similar sport or avocation? ☐ Yes ☐ No
Remarks: Give details for any question answered "Yes". Identify person affected._____

_____

_____

3) Driving Information

a) Driver License: Proposed Insured's # _____ State ____

b) Has any Proposed Insured been convicted with any moving violation or accident, had driving license suspended, or been convicted of driving under the influence of drugs or alcohol within the last 5 years? ☐ Yes ☐ No

4) Other Insurance

a) Has any company declined to issue, renew, or reinstate: rated, modified, postponed or cancelled any life or health insurance on any person covered? ☐ Yes ☐ No
b) Will insurance, including annuities, in any company, be discontinued or changed, or subject to borrowing of cash value, if the insurance applied for is issued? ☐ Yes ☐ No
c) Is any application for life or health insurance on Proposed Insured covered pending in any other company? ☐ Yes ☐ No

5) Annual Income Information Proposed Insured $_____ Other/Spouse $_____

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

Company or Society	Amount	Plan	Year Issued

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, prostrate 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
		(_____) _____-_____
		(_____) _____-_____

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 _____, 200_____

_____	_____	_____
Proposed Insured (Age 14 ½ or older)	Owner, if other than Proposed Insured	Adult and/or Member Applicant

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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.

_____	_____
Witness (Licensed Agent and Number where required)	Date

For Home Office Use: Assembly/Wreath # _____ Certificate # _____