SLOVAK CATHOLIC SOKOL

A Fraternal Benefit Society

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 Proposed 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 ☐ ☐

Basic Coverage: Face Amount $_____ Include Automatic Premium Loan? ☐ Yes ☐ No

☐ Whole Life ☐ Single Premium ☐ 3 Payment ☐ 10 Payment ☐ 20 Payment ☐ Other _____

Riders/Benefits Face Amount $_____ ☐ Accidental Death Benefit

☐ Waiver of Premium ☐ Payor Waiver of Premium ☐ Other _____

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

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

Existing Insurance: Do you have any 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.

List the life insurance and annuities now in force on the Proposed Insured; if there is additional insurance, list on a separate sheet.

Company	Year Issued	Plan	Amount

General Information:

1) Foreign Travel, Aviation, and Military Yes No

a) Does Proposed Insured intend to travel outside the U.S. or Canada within two years? ☐ ☐

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? ☐ ☐

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? ☐ ☐

2) Avocation and Sports

In the past three years, has Proposed Insured participated in, or intend to do so, any form of racing, skin or scuba diving, parachuting, hang gliding, rock climbing, or any similar sport or avocation? ☐ ☐

Remarks: Give details for any question answered "Yes". _____

_____

_____

3) Driving Information

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

b) Has Proposed Insured been convicted of 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 Proposed Insured? ☐ ☐

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? ☐ ☐

c) Is any application for life or health insurance on Proposed Insured covered pending in any other company? ☐ ☐

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

Personal Measurements: **Height:** ____ ft **____** in. **Weight** **_____** lbs.

Weight loss within the year? _____ Reason for change: _____

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, tumor, or any other growth? ☐ ☐

b) Diabetes or high blood pressure? ☐ ☐

c) Disease or disorder of the heart or blood? ☐ ☐

d) Coronary artery disease, abnormal ECG, chest pain, or peripheral vascular disease? ☐ ☐

e) Thyroid disorder, anemia, hepatitis, or glandular disorders? ☐ ☐

f) Stroke, TIA, or disease of the cardiovascular system or cerebrovascular system? ☐ ☐

g) Nervous or mental condition, epilepsy, or any disease or disorder of the brain or nervous system? ☐ ☐

h) Any disease or disorder of the lungs or respiratory system? ☐ ☐

i) Disease or disorder of the kidneys, bladder, prostate or reproduction system? ☐ ☐

j) Disease or disorder of the liver or the gastrointestinal system? ☐ ☐

k) Disorder of the muscles, bones, skin, or joints? ☐ ☐

l) Lupus or other connective tissue disease? ☐ ☐

m) Had abnormal diagnostic testing (excluding AIDS and HIV), or been aware of symptoms for which a doctor has not been consulted? ☐ ☐

3) Has Proposed Insured **ever** been advised to seek treatment for, or had treatment or counseling for, or joined a support group, for the use of alcohol? ☐ ☐

4) To the best of your knowledge and belief: Have you ever had, been told you had or have you ever been treated for Aid Immune Deficiency Syndrome (AIDS), Acquired Related Complex (ARC) or Aids related conditions? ☐ ☐

5) During the last 5 years has Proposed Insured been hospitalized or had surgery of any kind? ☐ ☐

6) Has Proposed Insured in the past 10 years:
   a) 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? ☐ ☐
7) Has Proposed Insured used any nicotine products (cigarettes, cigars, chewing tobacco, pipe, nicotine gum patch, or other)
   a) In the past 12 months? ☐ ☐
   b) In the past 36 months? ☐ ☐
   (If yes, list all products used) _____
8) Is Proposed Insured pregnant or expect to become pregnant within nine months? ☐ ☐
   (If yes, indicate anticipated date of delivery)
9) Is any medication currently prescribed for Proposed Insured? If "Yes", list them below. ☐ ☐
10) Has Proposed Insured had a parent or sibling:
   a) Diagnosed with cardiovascular disease, stroke or cancer prior to age 60? ☐ ☐
   b) Die from cardiovascular disease below age 60? ☐ ☐

Give Details for all "Yes" answers. (If additional space id needed, use a separate sheet, date and sign.)

Quest#	Dates	Medical Condition	Name of Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Please place additional Information on a separate sheet)

Physician Information (*If additional space is needed, use a separate sheet, dated and signed.)*

Name of Doctor	Address	Reason for Last Doctor Visit	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.

Massachusetts and Pennsylvania - Any person who knowingly 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.

AGREEMENT - AUTHORIZATION - ACKNOWLEDGMENT –SLOVAK CATHOLIC SOKOL

This authorization complies with the HIPAA Privacy Rule.

I understand I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of Slovak Catholic Sokol.

I, the Proposed Insured (or Owner signing below), by my signature set forth hereafter **AGREE** to the following.

(a) All Statements and answers in this application are complete and true to the best of my knowledge and belief.

(b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is delivered while the health of any Proposed Insured continues, without material change, to be as represented in this application.

(c) No agent has authority to waive any answer or otherwise modify this application or to bind Slovak Catholic Sokol, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this application.

(d) $_____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted

AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy benefits manager, insurance support organization, pharmacy/government agency, insurance or reinsuring company, MIB, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it

holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company, or its reinsurers, to release any information including my personal health information obtained to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 24 months from the date shown below. I know that I or my representative may request a copy of this authorization. It is understood that Slovak Catholic Sokol underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company, or its reinsurer, (or the Company, or its reinsurers, becomes obligated to report such codes to MIB) while this authorization is in force. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage.

ACKNOWLEDGE receipt of the following notices

(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and

(b) MIB Pre-Notice _____

Insured/Applicant Statements

I declare that the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief.

Signed at_____ this _____ day of _____, 20_____

_____	_____	_____
Proposed Insured (Age 18 or older)	Owner, if other than Proposed Insured	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 contract? ☐ Yes ☐ No

_____ #_____	_____	_____
Witness (Licensed Agent Signature and Number)	Print Name	Date

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NOTICE OF INFORMATION PRACTICES - This Notice Must be Given to Proposed Insured

(Including MIB Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING MIB, Inc ("MIB")

Information regarding your insurability will be treated as confidential. The Slovak Catholic Sokol, or its Reinsurer(s) may, however, make a brief report thereon to the MIB, a non-for profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of and information it may have in your file by calling (866) 692-6901 or you can go to their website www.mib.com. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB is 50 Braintree Hill Park, Suite 400, and Braintree, MA 02184.

Slovak Catholic Sokol, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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.