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 WI 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 WI Zip Code _____ Phone # (_____) _____-_____

Insurance Coverage

Face Amount $_____

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 ☐ Payor Waiver of Premium, Age of Payor ___ ☐ Term Rider

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.

	YES	NO
A. In the past 2 years, has the Proposed Insured:		
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

Massachusetts - 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 Secretary Administrations, 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 _____, 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? ☐ No. ☐ Yes. If Yes, any replacement regulations must be complied with.

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