

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)

a) Trust under the Insured's last will. **Primary** **Contingent**
 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.

<u>Company</u>	<u>Year Issued</u>	<u>Plan</u>	<u>Amount</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |

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? Yes No

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 |
| | <input type="checkbox"/> | <input type="checkbox"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Is any application for life or health insurance on Proposed Insured covered pending in any other company? | <input type="checkbox"/> | <input type="checkbox"/> |

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 |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Diabetes or high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Disease or disorder of the heart or blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Coronary artery disease, abnormal ECG, chest pain, or peripheral vascular disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Thyroid disorder, anemia, hepatitis, or glandular disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Stroke, TIA, or disease of the cardiovascular system or cerebrovascular system? | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Nervous or mental condition, epilepsy, or any disease or disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Any disease or disorder of the lungs or respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Disease or disorder of the kidneys, bladder, prostate or reproduction system? | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Disease or disorder of the liver or the gastrointestinal system? | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Disorder of the muscles, bones, skin, or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Lupus or other connective tissue disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Had abnormal diagnostic testing (excluding AIDS and HIV), or been aware of symptoms for which a doctor has not been consulted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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), or tested positive for HIV (Human Immunodeficiency Virus)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) During the last 5 years has Proposed Insured been hospitalized or had surgery of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |

- 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 is 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

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 _____

SLOVAK CATHOLIC SOKOL IS LICENSED TO DO BUSINESS IN THE STATE OF ILLINOIS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN THE ILLINOIS 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.

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

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.