

Czech Catholic Union

LONG FORM APPLICATION 1. PROPOSED INSURED	PART 1	Socie	ty	_ Certificate	::
Name:					
Address:					
City:					
DOB:/Age:	Sex: □ M □	F Birth Place:		_ Phone No.	.:
Social Security Number:		Email:			
Occupation: Emp	loyer:				
2. OWNER (If other than Proposed	Insured)				
Name:					
Address:					
City:					
DOB: / Age:	Sex: □ M □	F Soc. Sec. N	[o.:	_ Phone No.	:
Relationship to Insured:		Email	l :		
3. COVERAGE DETAILS					
Plan Type: Single Prem. 5 Pa	v Life □ 20 Pa	v Life □ Ord I	ife □ Term	□ Oti	her
Face Amount: Rider(s	•	•			
race Amount Rider(s) FIC	emium Conecteu	WIOU	e. \square Aimuai	
Primary Beneficiary(ies) (If more the	an one indicate s	hare (%) each is	to receive) Attac	ch additional	page if necessary.
Name:	Relationship:		_ Soc. Sec. No.	: ——	Share (%)
Address:	City:		State:	_ Zip Code:	
Name:	Relationship:		Soc. Sec. No.	:	_ Share (%)
Address:	City:		State:	Zip Code:	
Contingent Beneficiary(ies) (If more	than one indicat	te share (%) each	is to receive) A	ttach addition	nal page if necessary.
Name:	Relationship:		Soc. Sec. No.	:	_ Share (%)
Address:	City:		State:	Zip Code:	
Name:	Relationship:		_ Soc. Sec. No.	:	_ Share (%)
Address:	City:		State:	_ Zip Code:	
Existing Life Insurance? None Is discontinuing premium payments, so insurance policy or contract being contract.	surrendering, fort	'es □ No Is us	to the insurer or sing funds from	the existing	policy or contract to p
premiums due on the insurance appl appropriate replacement forms.) Name of Company Date of Issue			□ Yes □ No ness/Personal)	•	mplete below and substant Dunt Replacement?

LONG FORM APPLICATION PART 2

	Please provide details to "Yes" answers in Remarks Section					
	Has the Proposed Insured used any form of tobacco within the past 12 months?					
2.	Has the Proposed Insured within the past 5 years:					
	a) Been charged with a driving while impaired (alcohol, drugs, other) violation, had driver's license revoked	_	_			
	or suspended, or within the last 24 months received 3 or more citations for moving violations?					
	b) Had an application for insurance been declined, rated, or postponed?					
	c) Flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so?					
	d) Engaged in parachuting, scuba diving, racing or other hazardous sport or intend to do so?					
	e) Used or is now currently using marijuana, narcotics, intravenous drugs, cocaine, barbiturates,					
	hallucinogens, or been treated for drug or alcohol abuse or been advised by a doctor to limit the use of alcohol or any medication, prescribed or not?					
	f) Used any alcoholic beverage?					
	(if Yes provide type, frequency, and amount) Type Frequency Amount	Ш	Ш			
2	g) Been on parole or probation, charged with a felony or misdemeanor, or awaiting trial for a felony?					
	Does the Proposed Insured intend to travel or reside outside the U.S. or Canada?		_			
4.	Is the Proposed Insured a U.S. Citizen or currently have a valid U. S Permanent resident card/green card?					
	(if No, provide details including country, type of visa, expiration date)					
5.	A) For the Proposed Insured, please answer the following:					
	Height Weight Change in Past Year? Cause of Weight Gain/Los	SS				
	Lbs.					
	Name and Address of your usual medical advisor?					
	Date and reason of last visit?		_			
	What treatment was given or medication prescribed? (if None, then write None)					
6.	Has the Proposed Insured ever had, or been told they had, or received treatment or advice by a physician or					
		YES	NO			
	a) Abnormal blood pressure, chest pain, coronary artery disease, abnormal ECG, elevated cholesterol, stroke,					
	transient ischemic attack (TIA), peripheral vascular disease or any other disorder or disease of the heart, blood vessels or of the cerebrovascular system?					
	blood vessels or of the cerebrovascular system?					
	b) Cancer, tumor, polyps, basal or squamous cell carcinoma, abnormal moles or lesions, dysplastic nevi, malignant melanoma or any other malignancy, or any growth or lump that has not been evaluated by a physician?					
	melanoma or any other malignancy, or any growth or lump that has not been evaluated by a physician?					
	c) Diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder?					
	d) Any ear, nose, throat, lung disorder, or any respiratory disorder, to include sleep apnea? Any disorder of the stemach intestines restum liver or paperses kidney or bladder?					
	e) Any disorder of the stomach, intestines, rectum, liver, or pancreas, kidney or bladder? (b) Lypus connective tissue disease or any injury to or disease of the bones, myseles, injury to or disease of the bones, myseles, injury to or disease of the bones, myseles, injury to or disease.					
	f) Lupus, connective tissue disease, or any injury to or disease of the bones, muscles, joints, eyes, or skin? g) Epilepsy, seizures, brain disorder, tremor, multiple sclerosis, paralysis, Parkinson's, Alzheimer's, motor	Ш	Ш			
	neuron disease or any other disease or disorder of the nervous system?	_				
	h) Anxiety, depression, or an emotional, behavioral, mental or nervous disorder?					
	i) Any disease, disorder, or abnormal screening or diagnostic tests related to the breast or reproductive organs	_				
	j) AIDS (acquired immune deficiency syndrome), positive HIV test, or any other immunological disorder?					
7	Other than as stated above, has the Proposed Insured, within the past 5 years:	Ш	Ш			
٠.	a) Consulted, received treatment or advice from, been prescribed medication by any other medical advisor?					
	b) Had any abnormal diagnostic or screening tests or within the past 2 years been advised to have any					
	diagnostic test, hospitalization, surgical procedure or treatment that has not been done?	П				
	c) Been aware of any symptoms for which a medical advisor has not yet been consulted?					
8.	Has any of Proposed Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer, strok	e	_			
	J					
	or any other hereditary disease?					
	or any other hereditary disease? (if Yes, indicate family member, illness, age at onset of illness and, if applicable, age at death)	_				
9.	(if Yes, indicate family member, illness, age at onset of illness and, if applicable, age at death) REMARKS (Explain "Yes" answers to Questions 1 - 8) (Attach additional sheet if necessary.)					
9.	(if Yes, indicate family member, illness, age at onset of illness and, if applicable, age at death)		ıls			
9.	(if Yes, indicate family member, illness, age at onset of illness and, if applicable, age at death) REMARKS (Explain "Yes" answers to Questions 1 - 8) (Attach additional sheet if necessary.)		ıls			
9.	(if Yes, indicate family member, illness, age at onset of illness and, if applicable, age at death) REMARKS (Explain "Yes" answers to Questions 1 - 8) (Attach additional sheet if necessary.)		ls			

10. Does any person named as Primary or Contingent Beneficiary lack an insurable interest - A connection by blood of the beneficiary to the insured beneficiary stands to suffer financial loss by reason the death of the insured	d or an economic connection under which the
If yes, please explain:	i. Les Lino
11. Is any portion of the premium on the policy applied for, to be paid in whole forgiveness of a loan used to fund premiums?	e or in part through an assumption and/or Yes No
LONG FORM ADDITION DADT 2	
LONG FORM APPLICATION PART 3 Admission to Membership	
If not currently a member, the Proposed Insured hereby requests admission to re-	membership in the Czech Catholic Union.
Notice to Proposed Insured I understand that information regarding insurability will be treated as confidentic may, however make a brief report of my personal health information to MIB, In life insurance companies, which operates an information exchange on behalf of member company for life or health insurance coverage or a claim for benefit request, will supply such company with the information it may have about m reinsurer(s) may also release information in its file to other insurance comp insurance, or to whom a claim for benefits may be submitted. Upon receipt of of any information in my file. (Medical information will be disclosed to my atter of the information in the MIB's file, I may contact MIB and seek a correction the Federal Fair Credit Reporting Act. The address of MIB's information office Massachusetts 02184-8734.	nc., a not for profit membership organization of of its members. Should I apply to another MIB is is submitted to such a company, MIB, upon the in its files. The Czech Catholic Union or its anies to whom I may apply for life or health a request from me, MIB will arrange disclosure anding physician only). If I question the accuracy in accordance with the procedures set forth in
Authorization	
I hereby authorize any licensed physician, medical practitioner, hospital, clinsurance company, MIB Inc., ("MIB") or other organization, institution or per or my health, to give the Czech Catholic Union, or its representatives, includinformation. The Czech Catholic Union may disclose such information to its refor 30 months after the date shown below. A photographic copy of this auth Insured or a Duly-Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of this Authorized Representative has the right to a copy of the	erson, that has any records or knowledge of meding Equifax or bearer, or reinsurer, any such einsurer(s) MIB, Inc. This authorization is valid orization shall be as valid as the original. The
THE CZECH CATHOLIC UNION IS LICENSED TO DO BUSINESS ORGANIZATION FRATERNAL BENEFIT SOCIETIES ARE NOT IT ASSOCIATION. THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES OR OTHER FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OF ITS OF THE IMPAIRMENT OF RESERVES, A CERTIFICATE (POLICY) PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS (POLICY) ISSUED BY THE SOCIETY.	NCLUDED IN THE STATE GUARANTY ETIES CANNOT BE ASSESSED FOR THE NAL BENEFIT SOCIETIES. BY LAW, A DWN SOLVENCY. IF THERE IS AN HOLDER MAY BE ASSESSED A
I AGREE THAT NO INSURANCE SHALL TAKE EFFECT UNLESS AND paid; (2) a certificate is delivered to the Owner during the Proposed Insured's	
is as described in the application; and (4) all requirements of the Constitution a	
Signed at, X_	, , , , , , , , , , , , , , , , , , ,
City State Date s	IGNATURE OF PROPOSED INSURED (IF AGE 18 OR OVER) DR PARENT OR GUARDIAN (JUVENILE APPLICATIONS)
	IGNATURE OF OWNER F OTHER THAN PRIMARY PROPOSED INSURED)
Identity Verified by: □ Driver's License No o	or Other
A person who knowingly presents a false or fraudulent claim for paymentalse information in an insurance application may be guilty of a crime subj	
For Home Office Use	jeet to mies.
☐ Approved Remarks:	
☐ Disapproved	
Dated: S	igned: