Czech Catholic Union

5349 Dolloff Road – Cleveland, OH 44127 – 216-341-0444 – 216-342-0711 Fax

LONG FORM APPLICATION PART 1 Society _____ Certificate: _____

1. PROPOSED INSURED

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: ___/____/____ Age: _____ Sex: ☐ M ☐ F Birth Place: _____ Phone No.: _____

Social Security Number: _____ Email: _____

Occupation: _____ Employer: _____

2. OWNER (If other than Proposed Insured)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: ___/____/____ Age: _____ Sex: ☐ M ☐ F Soc. Sec. No.: _____ Phone No.: _____

Relationship to Insured: _____ Email: _____

3. COVERAGE DETAILS

Plan Type: ☐ Single Prem. ☐ 5 Pay Life ☐ 20 Pay Life ☐ Ord. Life ☐ Term_____ ☐ Other _____

Face Amount: _____ Rider(s): _____ Premium Collected: _____ Mode: ☐ Annual ☐ Other _____

Primary Beneficiary(ies) (If more than one indicate share (%) each is to receive) Attach 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 indicate share (%) each is to receive) Attach 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: _____

Existing Life Insurance? ☐ None **Pending Life Insurance?** ☐ None

Is discontinuing premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating an existing life insurance policy or contract being considered? ☐ Yes ☐ No Is using funds from the existing policy or contract to pay premiums due on the insurance applied for herein being considered? ☐ Yes ☐ No (If yes, complete below and submit appropriate replacement forms.)

Name of Company	Date of Issue	Life Amount	Purpose (Business/Personal)	ADB Amount	Replacement?
					☐ Yes ☐ No
					☐ Yes ☐ No

LONG FORM APPLICATION PART 2

Please provide details to "Yes" answers in Remarks Section **YES** **NO**

1. 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_____
   g) Been on parole or probation, charged with a felony or misdemeanor, or awaiting trial for a felony?
3. 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/Loss
____	____	____Lbs. ☐ Gain ☐ Loss	_____

   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 been diagnosed or received treatment by a physician or someone in the medical field for: **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? ☐ ☐
   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? ☐ ☐
   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? ☐ ☐
   e) Any disorder of the stomach, intestines, rectum, liver, or pancreas, kidney or bladder? ☐ ☐
   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 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:
   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? ☐ ☐
   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, stroke, or any other hereditary disease? ☐ ☐
   (if Yes, indicate family member, illness, age at onset of illness and, if applicable, age at death)
9. **REMARKS (Explain "Yes" answers to Questions 1 - 8) (Attach additional sheet if necessary.)**
   Name of Person(s) Illness Date & Duration Treatment & Results Doctors & Hospitals
   _____
   _____

10. Does any person named as Primary or Contingent Beneficiary lack an insurable interest* in the Proposed Insured?
    * *Insurable interest - A connection by blood of the beneficiary to the insured or an economic connection under which the beneficiary stands to suffer financial loss by reason the death of the insured.* ☐ Yes ☐ No
    If yes, please explain:_____
11. Is any portion of the premium on the policy applied for, to be paid in whole or in part through an assumption and/or forgiveness of a loan used to fund premiums? ☐ Yes ☐ No

LONG FORM APPLICATION PART 3

Admission to Membership

If not currently a member, the Proposed Insured hereby requests admission to membership in the Czech Catholic Union.

Notice to Proposed Insured

I understand that information regarding insurability will be treated as confidential. The Czech Catholic Union or its reinsurer(s), may, however make a brief report of my personal health information to MIB, Inc., a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should I 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 about me in its files. The Czech Catholic Union or its reinsurer(s) may also release information in its file to other insurance companies to whom I may apply for life or health insurance, or to whom a claim for benefits may be submitted. Upon receipt of a request from me, MIB will arrange disclosure of any information in my file. (Medical information will be disclosed to my attending physician only). If I question the accuracy of the information in the MIB's file, I 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's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, MIB Inc., ("MIB") to give the Czech Catholic Union, or its representatives, including Equifax or bearer, or reinsurer, any such information. The Czech Catholic Union may disclose such information to its reinsurer(s) MIB, Inc. This authorization is valid for 30 months after the date shown below. A photographic copy of this authorization shall be as valid as the original. The Insured or a Duly-Authorized Representative has the right to a copy of this Authorization.

THE CZECH CATHOLIC UNION IS LICENSED TO DO BUSINESS IN THE STATE OF ILLINOIS AS A FRATERNAL BENEFIT SOCIEY. AS SUCH, IT IS NOT INCLUDED IN THE ILLINOIS LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOW 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 (POLICY) HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE (POLICY) ISSUED BY THE SOCIETY.

I AGREE THAT NO INSURANCE SHALL TAKE EFFECT UNLESS AND UNTIL (1) the first premium shall have been paid; (2) a certificate is delivered to the Owner during the Proposed Insured's lifetime; (3) the health of the Proposed Insured is as described in the application; and (4) all requirements of the Constitution and Bylaws have been complied with.

Signed at _____, _____ _____ X_____
City State Date SIGNATURE OF PROPOSED INSURED (IF AGE 18 OR OVER) OR PARENT OR GUARDIAN (JUVENILE APPLICATIONS)

X_____ X_____
SIGNATURE OF HOME OFFICE REPRESENTATIVE OR PRODUCER SIGNATURE OF OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

Identity Verified by: ☐Driver's License No._____ or ☐Other _____

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an insurance application may be guilty of a crime subject to fines.

For Home Office Use

☐ Approved Remarks:_____
☐ Disapproved _____

Dated:_____ Signed:_____