Czech Catholic Union

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

SHORT 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

SHORT FORM APPLICATION PART 2

Personal Health Statement of Proposed Insured

1. Height: _____ Weight: _____
2. Doctor's Name, Address and Phone # _____
3. Has the Proposed Insured used any form of tobacco within the past 12 months? ☐ Yes ☐ No
4. Is the Proposed Insured currently hospitalized, bedridden or confined to a wheelchair? ☐ Yes ☐ No

SHORT FORM APPLICATION PART 2 - CONTINUED

5. In the past five (5) years has the Proposed Insured been hospitalized or received medical treatment or advice by a physician or someone in the medical field for any illness, disease, injury or physical condition? ☐ Yes ☐ No

6. Does the Proposed Insured have any physical or mental handicaps? ☐ Yes ☐ No

7. Give details to "Yes" answers to Questions 3, 4 5 and 6 above: _____

_____

8. 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: _____

9. 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

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, or 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_____

SIGNATURE OF HOME OFFICE REPRESENTATIVE OR PRODUCER

X_____

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: _____