

# Polish Women's Alliance of America

6643 N. Northwest Highway, Chicago, IL 60631

888-522-1898 ■ [www.pwaa.org](http://www.pwaa.org)

A Fraternal Benefit Society

## ANNUITY APPLICATION

### PROPOSED ANNUITANT Information

Name	Social Security Number	Date of Birth
Address	Home Phone Number	Daytime Phone Number
City/State/Zip	Sex (Male or Female)	E-mail Address

### OWNER (if other than annuitant) Information

Name	Social Security Number	Date of Birth
Address	Home Phone Number	Daytime Phone Number
City/State/Zip	Sex (Male or Female)	E-mail Address

### BENEFICIARY Information

<input type="checkbox"/> Primary Beneficiary		<input type="checkbox"/> Contingent Beneficiary	
Name	Relationship	Name	Relationship
Social Security Number/Tax I.D. Number	Date of Birth	Social Security Number/Tax I.D. Number	Date of Birth
Address		Address	
City/State/Zip		City/State/Zip	
<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary		<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary	
Name	Relationship	Name	Relationship
Social Security Number/Tax I.D. Number	Date of Birth	Social Security Number/Tax I.D. Number	Date of Birth
Address		Address	

### PLAN Information

Non-Qualified Annuity  
 Qualified Annuity:  
 IRA  ROTH IRA  
 Other: \_\_\_\_\_

### DEPOSIT Information

Non-Qualified Contribution: \$ \_\_\_\_\_  
 Qualified Contribution:  
 Contribution \$ \_\_\_\_\_ Tax Year \_\_\_\_\_  
 Contribution \$ \_\_\_\_\_ Tax Year \_\_\_\_\_  
 Regular  Direct Transfer  Rollover  1035 Exchange  
 Roth Conversion  Other: \_\_\_\_\_

### OTHER Information

Does the proposed annuitant have any existing insurance?  Yes  No

If yes, list below details of insurance or annuities in force on proposed annuitant (if none, write none). Attach a separate sheet if necessary.

Insurer	Life or Annuity Insurance	Year issued	Face amount	ADB amount	Replacing Yes/No

Annuitant/owner: The above information about existing insurance is correct. \_\_\_\_\_ (Annuitant/Owner signature)

Representatives: To the best of my knowledge, the above information about existing insurance is correct. \_\_\_\_\_ (Representative/witness signature)

Annuitant/owner: Will this annuity replace or change any of the above life insurance certificates or annuities?  
 Yes  No \_\_\_\_\_ (Annuitant/Owner signature)

Representative: To the best of my knowledge, will the annuity being applied for replace any existing life or annuity insurance on the insured?  
 Yes  No \_\_\_\_\_ (Representative/witness signature)

AA FPDA2013 MD

## RECEIPT

POLISH WOMEN'S ALLIANCE OF AMERICA (PWA), 6643 N. Northwest Highway, Chicago, IL 60631

Received from: \_\_\_\_\_ the sum of: \_\_\_\_\_ with an annuity application for: \_\_\_\_\_

This Receipt is not valid unless: (1) it is signed by our representative or witness; and (2) the payment tendered is good and collectible.

**NOTE:** Please notify PWA if you do not receive your contract or a refund of the amount paid within 30 days from the date of this Receipt.

Received by: \_\_\_\_\_ Date: \_\_\_\_\_ **MAKE ALL REMITTANCES PAYABLE TO POLISH WOMEN'S ALLIANCE OF AMERICA. DO NOT MAKE PAYABLE TO THE REPRESENTATIVE OR LEAVE THE PAYEE BLANK.**

Remarks:

**AGREEMENT**

If I am not already a PWA member, I hereby apply for membership in the Polish Women’s Alliance of America, a fraternal benefit Society. I agree to be governed by the bylaws of the Society.

Under penalties of perjury, I certify that the Social Security number and/or Employer Identification number listed on this form is my correct Taxpayer Identification number.

**THE UNDERSIGNED:** (1) **REPRESENT** that the information shown in this application is complete and true, to the best of their knowledge and belief; (2) **AGREE** that this application shall be the basis for and a part of any contract issued; and (3) **UNDERSTAND** that: (a) **the contract applied for shall be effective on the later of the date the Polish Women’s Alliance of America approves issue of the contract applied for or the date it receives the initial premium for the contract;** and (b) only the Officers of the Polish Women’s Alliance of America may, in writing, make or change a contract or waive any of its rights or requirements.

Owner signed at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_  
City State (Month/Year)

X \_\_\_\_\_  
Proposed Annuitant’s Signature

X \_\_\_\_\_  
Signature of Witness or Authorized Representative

X \_\_\_\_\_  
Signature of Owner (if other than proposed annuitant), Relationship

X \_\_\_\_\_  
Witness or Authorized Representative’s Printed Name

**FOR HOME OFFICE USE ONLY**

Contract No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

**FRAUD NOTICES. For your protection, certain states require that the following notices appear on this form.**

**California.** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**District of Columbia.** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida.** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Indiana.** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Maryland.** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey.** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Ohio.** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Pennsylvania.** 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.

**FOR ALL OTHER STATES EXCLUDING CONNECTICUT.** A person may be committing insurance fraud, if he or she submits an application or claim containing a false or deceptive statement with intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

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