POLISH WOMEN'S ALLIANCE OF AMERICA
A Fraternal Benefit Society
6643 N. Northwest Hwy, Chicago, IL 60631

LIFE INSURANCE, APPLICATION

Please Print, Use Dark Ink

1. **PROPOSED INSURED:** ☐Female ☐Male
   a. Name:_____
   First - Mi - Last
   b. Address:_____ City/State/Zip: _____
   E-mail address:_____ Tel No.: _____
   c. Date of Birth:_____ Place of Birth: _____
   Mo – Day – Yr *State/Country*
   d. Height:_____ Weight:_____ Soc. Sec. No.:_____
   e. Occupation:_____ How Long:_____
   f. Member of Polish Women's Alliance of America: ☐Yes ☐No If no, apply for membership.

2. **OWNER (**if other than insured): Name: _____
   Relationship: _____ Soc. Sec. No.:_____ Date of Birth:_____ Sex: _____
   Address:_____ City/State/Zip: _____
   E-mail address:_____ Tel No.:_____

3. **PLAN**:_____ Face Amount:_____
   a. Premium Mode: ☐ Ann. ☐ S-Ann. ☐ Quar. ☐ Mo. ☐ Single Pay Amount paid with this application:_____
   b. Dividend Option: ☐ Cash ☐ Reduce Premium ☐ Paid-Up Additions ☐ Accumulate

4. **BENEFICIARY Information**:
   ☐ **Primary Beneficiary**
   Name:_____ Relationship: _____Tel No.: _____
   Address:_____ City/State/Zip: _____
   ☐ **Contingent Beneficiary**
   Name:_____ Relationship: _____Tel No.: _____
   Address:_____ City/State/Zip: _____
   (If additional space is needed, use separate sheet, indicate whether Primary or Contingent, dated and signed.)

5. In the past 3 years, has the Proposed Insured:
   a. Used tobacco in any form: ☐ No ☐ Yes
   b. Engaged in: scuba or sky diving; or, boat, car or motorcycle racing: ☐ No ☐ Yes
   c. Flown as the pilot or crewmember of any form of aircraft: ☐ No ☐ Yes
   d. Had any license to drive suspended or revoked: ☐ No ☐ Yes
   e. Details any Yes answer: _____
   _____
   (If additional space is needed, use separate sheet, dated and signed.)

6. a. In the past 5 years, has the Proposed Insured: been diagnosed or treated by a physician or been confined in a medical care facility, for: (Circle any applicable condition)?
   (1) cancer, tumor or malignancy; diabetes; heart or circulatory disease or disorder; high blood pressure; kidney or genito-urinary disease or disorder; lung or respiratory disease or disorder; epilepsy or mental or nervous disease or disorder; stroke; any disease or disorder of the stomach, intestines, gall bladder, liver or rectum:
   ☐ No ☐ Yes
   (2) any disease or disorder not listed above or any surgical operation scheduled or contemplated:
   ☐ No ☐ Yes
   b. In the past 5 years has the Proposed Insured been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS): ☐ No ☐ Yes
   c. **Details, any Yes answer in a or b above. Show: condition, dates, and name(s) and address(s) of physician(s) and medical care facilities.**
   _____
   _____
   _____
   (If additional space is needed, use separate sheet, dated and signed.)

7. Will the insurance applied for replace or change any existing insurance or annuity? ☐ No ☐ Yes; show name of insurer(s) and contract number(s):_____
   _____

8. **Special Requests:**

* * * * *

Each person signing this application: (1) **REPRESENTS** that, to the best of such person's knowledge and belief, all statements and answers included herein are complete, true and accurately recorded; (2) **AGREES** that this application shall be the basis for and a part of any life insurance contract issued; and (3) **UNDERSTANDS** that no agent or person other than an executive officer of Polish Women's Alliance of America may, in writing: (a) change, modify or waive any of the printed statements herein; or (b) waive any of the rights or requirements of the Polish Women's Alliance of America.

Except as may be provided in a Conditional Receipt, bearing the same date and payment amount as shown in this application, no insurance shall take effect unless and until: (1) this application is approved by the Polish Women's Alliance of America; (2) a contract of life insurance is issued; and (3) the full first premium is paid. All such conditions, must be met while the health and other factors affecting the insurability of the Proposed Insured remain as described in this application.

AUTHORIZATION. The undersigned hereby authorizes any of the following who may have any records or information regarding the Proposed Insured:

physician or medical practitioner; medical care facility; the Medical Information Bureau (MIB); consumer reporting agency; insurer; employer; institution; organization; or, person,

to provide such records or information to: the Polish Women's Alliance of America, its reinsurer, or, except for the MIB, its legal agent. The Polish Women's Alliance of America or its reinsurer may release any such records or information: to the MIB; to other insurers in which the Proposed Insured may have insurance, to whom the Proposed Insured may apply for insurance or to whom a claim may be submitted; or, as may be lawfully required. The Polish Women's Alliance of America may, at its discretion, obtain an investigative consumer report. Any records or information obtained will be treated as confidential and, be used to determine eligibility for insurance or benefits. I further authorize the Polish Women's Alliance of America or to its reinsurer to make a brief report of my personal information to MIB, Inc.

On request, the Polish Women's Alliance of America will provide a copy of this Authorization. This Authorization shall be valid for a period of 24 months from the date shown below. A photocopy shall be valid as the original.

Signed at City/State)_____ this _____ day of_____, 20____

_____ _____

Proposed Insured (Age 18 or older) Owner, if other than Proposed Insured

Witness /Licensed Agent: _____

Print Name:_____ License I.D. #:_____

Agent's Statement: To the best of your knowledge and belief, will the insurance applied for replace or change any existing insurance or annuity? ☐ No ☐ Yes

For Home Office Use: Certificate 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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.

Polish Women's Alliance of America **CONDITIONAL RECEIPT**
6643 N . Northwest Highway
Chicago, IL 60631

THIS RECEIPT DOES NOT PROVIDE INSURANCE UNTIL ITS CONDITIONS ARE MET

Received from:_____ in connection with an application on

the life of _____, the sum of $_____.

Date:_____ Agent: _____

Provided the following conditions are met, exactly, the insurance applied for will be effective on the later of: (1) the date of the application or (2) the last date of any initially required test(s) or examination(s) or (3) an effective date requested in the application.

1. The Proposed Insured is found to be a standard risk for the amount and plan applied for in accordance with our underwriting rules then in effect.
2. The amount paid is sufficient to pay the first mode premium for the amount and plan applied for including any Riders.
3. The amount paid is good and collectible.

Maximum Amount. The maximum amount of insurance which may become effective under this Conditional Receipt is $50,000. The maximum amount shall include: (1) any accidental death benefits applied for; and (2) any other pending application for the Proposed Insured.

Please contact the Polish Women's Alliance of America if you do not, within 60 days from the date of this Conditional Receipt, receive the life insurance certificate applied for or, a refund of the amount paid. Please include the name of the agent and, the date and amount paid.

Do not pay in cash. All remittances should be payable to PWAA. Do not make payable to the agent or leave the payee blank. If paying by Credit Card, a completed Credit Card authorization form must accompany this application.

Form LA-0900 2013 CR

Polish Women's Alliance of America (PWAA)
(Detach and give to Applicant)

CONSUMER REPORT **Notice, Part 1**

This notice is to inform you that PWAA may obtain an investigative consumer report. If obtained, the report will include information obtained through personal interviews with third parties such as: financial sources, business associates, family members, friends, neighbors, or others with whom you are acquainted. The report may include information as to your: character, general reputation, personal characteristics, and mode of living. You may, within a reasonable period of time, request, in writing, additional, detailed information regarding the nature and scope of any such report.

Form LA-0900 N1

Polish Women's Alliance of America (PWAA)
(Detach and give to Applicant)

MEDICAL INFORMATION BUREAU (MIB) **Notice, Part 2**

Information regarding your insurability will be treated as confidential. PWAA's reinsurer may, however, make a brief report thereon to the MIB, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member for life or health insurance coverage, or if a claim for benefits is submitted to such member, the MIB will, upon request, supply such member with the information it may have in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the MIB file information, you may contact the MIB and seek a correction in accordance with procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; telephone: (866) 692-6901 (TTY 866-346-3642).

Form LA-0900/MIB