APPLICATION FOR INDIVIDUAL LIFE INSURANCE

FCSU Financial®
• A FRATERNAL BENEFIT SOCIETY •

FIRST CATHOLIC SLOVAK UNION
of the United States of America and Canada
Herein called FCSU
6611 Rockside Road, Suite 300, Independence, Ohio 44131
800.533.6682 · fcsu@fcsu.com · www.fcsu.com

For Home Office Use Only
Policy #: _____
Branch #: _____
Approved by: _____

A. IDENTIFICATION OF PROPOSED INSURED

Is the applicant a member of FCSU? ☐ Yes ☐ No If yes, Preferred Branch #: _____

1a. Full Name of Proposed Insured: _____ 1b. Sex ☐ Male ☐ Female
(Complete in all cases. This person will also be the Policy Owner, unless the Owner section is completed below.)

1c. Phone: _____ 1d. Social Security #: _____

2. Address: _____ City: _____ State: _____ Zip: _____

3a. DOB (Month, Day, Year): _____ 3b. Age: _____ 3c. Birthplace: _____

3d. Email: _____

4. US Citizen: ☐ Yes ☐ No

5. Name of Employer: _____

6. Address: _____ Phone: _____

7a. Occupation: _____ 7b. How long employed: Years: _____ Months: _____

7c. Describe Duties: _____

B. OWNER — Complete if Owner is other than Proposed Insured (Minimum age of ownership is 18)

1. Full Name of Individual/Entity*: _____ 2. DOB (Month, Day, Year): _____

3. Address: _____ City: _____ State: _____ Zip: _____

Social Security/Tax ID #: _____ Relationship: _____ 4. Phone: _____

*If an Entity, name a contact person: _____ Phone: _____

C. PLAN TYPE

1. ☐ Single Premium Whole Life ☐ 10 Year Level Term 2. Face Amount of Insurance: $ _____
☐ 20 Year Pay Whole Life ☐ 20 Year Level Term
☐ Ordinary Whole Life ☐ or Other Class: _____
☐ JEP Term to Age 25

3. Riders are available for 20 Pay, Ordinary or 10 & 20-Year Term — Rider Amount
a. ☐ Accidental Death Benefit $ _____
b. ☐ Waiver of Premium $ _____
c. ☐ Other: _____ $ _____

4. Include Automatic Premium Loan (If applicable)? ☐ Yes ☐ No

5. Premium Mode: ☐ Single ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

6. Dividend Election: ☐ Cash ☐ Accumulate at Interest ☐ Paid up Additions ☐ Reduced Premium

D. BENEFICIARY — To name additional Primary and Contingent Beneficiaries, sign, date and list names on a separate sheet of paper

1. **Primary Beneficiary** Will receive proceeds unless changed by the Owner.

Name	Address	Social Security #	Phone	Relationship	Share

2. **Contingent Beneficiary**

3. **Trust as Beneficiary**

a. Trust Name: _____ ☐ Primary ☐ Contingent

b. Trust Date: _____ Tax ID: _____

E. GENERAL INFORMATION

1. Foreign Travel, Aviation, and Military
   a. Does the Proposed Insured intend to travel outside the U.S. or Canada within two years? ☐ Yes ☐ No
   b. Except as a passenger on a regularly scheduled flight, does the Proposed Insured intend to fly or has he/she flown during the past two years? ☐ Yes ☐ No
   c. Has the Proposed Insured entered into a written agreement to become a member of the Armed Forces (including Reserves and National Guard)? ☐ Yes ☐ No
2. Avocation and Sports
   In the past three years, has the Proposed Insured participated in: (1) any form of racing; (2) skin or scuba diving; (3) parachuting; (4) hang gliding; (5) rock climbing; or (6) any similar sport or avocation? ☐ Yes ☐ No

   Give Details: Give details for any questions answered "Yes":

   _____

   _____

3. Driving Information
   a. Proposed Insured's Driver's License #: _____ State _____
   b. Has the Proposed Insured: (1) been convicted with any moving violation; or (2) accident at fault within the last 5 years? ☐ Yes ☐ No
4. Has the Proposed Insured been convicted of a felony or currently on parole or probation? ☐ Yes ☐ No
5. Annual Income Information Proposed Insured $ _____ Other/Spouse $ _____
6. a. Does the Proposed Insured or applicant have existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☐ No
   b. Has any company declined to: issue; renew; or reinstate: rated; modified; postponed or cancelled any life or health insurance on the Proposed Insured? ☐ Yes ☐ No
   c. Will the insurance applied for replace or change any insurance or annuities? ☐ Yes ☐ No
   If yes, Name of Company: _____
   Policy # _____ Amount: $ _____
   d. Is any application for life or health insurance on the Proposed Insured pending in any other company? ☐ Yes ☐ No

F. MEDICAL INFORMATION

1. Proposed Insured Height/Weight: **Height** ____ **ft.** ____ **in. Weight** _____ Any weight changes in the last year? ☐ Yes ☐ No
2. **During the past five years**, has the Proposed Insured been examined or prescribed medication by a physician or a member of the medical profession? ☐ Yes ☐ No
3. Has the Proposed Insured **ever** been treated for, or been diagnosed by a physician as having:
   a. Cancer; diabetes; or high blood pressure? ☐ Yes ☐ No
   b. Disease or disorder of the heart or blood? ☐ Yes ☐ No
   c. Nervous or mental condition; or any disease or abnormality of the brain or nervous system? ☐ Yes ☐ No
   d. Any disease or abnormality of the lungs or respiratory system? ☐ Yes ☐ No
   e. Disease or abnormality of the kidneys; liver; prostrate or genitourinary system? ☐ Yes ☐ No
   f. Disease or abnormality of the gastrointestinal system? ☐ Yes ☐ No
   g. Disorder of the muscles; bones; or joints? ☐ Yes ☐ No

F. MEDICAL INFORMATION (Continued)

4. Has the Proposed Insured **ever:** been advised to seek treatment or counseling; been treated for or received counseling; or joined a support group for the use of alcohol? ☐ Yes ☐ No
5. Has the Proposed Insured **ever** been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
6. During the last 5 years has the Proposed Insured been hospitalized or had surgery of any kind? ☐ Yes ☐ No
7. Has the Proposed Insured:
   a. Other than a one-time or experimental basis, used: barbiturates; heroin; cocaine; marijuana; or any illegal, restricted or controlled substance, except as prescribed by a physician? ☐ Yes ☐ No
   b. Been advised to seek, or received medical treatment for drug use; or been convicted for drug use; or pled guilty to charge of drug use or distribution? ☐ Yes ☐ No
8. Has the Proposed Insured used any nicotine products? (cigarettes; cigars; chewing tobacco; pipe; nicotine gum; patch; or other)
   a. In the past 12 months ☐ Yes ☐ No
   b. In the past 36 months ☐ Yes ☐ No
   If yes, list all products used: _____
9. Is the Proposed Insured pregnant? If yes, indicate anticipated date of delivery. ☐ Yes ☐ No
10. Has the Proposed Insured not completed any recommended diagnostic testing or surgery in the past 5 years? If yes provide details below. ☐ Yes ☐ No
11. Is the Proposed Insured currently prescribed any medication? If yes, provide the name of prescribed medications below. ☐ Yes ☐ No
12. Has the Proposed Insured had a parent or sibling:
   a. Diagnosed or treated by a member of the medical profession with: cardiovascular disease; stroke; or cancer prior to age 60? ☐ Yes ☐ No
   b. Die from cardiovascular disease below age 60? ☐ Yes ☐ No

Please Provide Details for all "Yes" answers: (Please provide additional information on a separate sheet of paper)

Question #	Dates	Medical Condition	Name of Doctor

Physician Information:

Name of Doctor: _____ Phone: _____

Address: _____

G. OTHER ITEMS

1. Do you as the applicant or Proposed Insured declare on behalf of yourself and any person who shall have an interest in any contract issued hereunder, that you have read each of the above answers and that to the best of your knowledge and belief they are full, complete and true?
   Answer: _____
2. Do you as the applicant or Proposed Insured agree that the acceptance of the contract with copy of this application attached constitutes ratification by applicant or corrections and additions by FCSU in the space below except there can be no change of amount, classification, age at issue, kind or plan of insurance or benefits, unless agreed to in writing?
   Answer: _____

H. JUVENILE SECTION — Answer following questions only for life insurance on child under age 18 (complete ownership Section B)

1. Applicant's Name: _____ 2. Relationship: _____
3. Address **If different from No. A2:** _____
4. Total amount of Life Insurance in force on the Applicant: $ _____
5. Applicant's Birthday (Month, Day, Year): _____ Age: _____ Birthplace: _____ 6. Occupation: _____
7. Has child had any birth injury or any congenital or hereditary abnormality or disease which may affect the child's future health?
   ☐ Yes ☐ No If yes, give details: _____

I. AGREEMENT-AUTHORIZATION-ACKNOWLEDGMENT

This authorization complies with the HIPAA Privacy Rule.
I understand I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of FCSU.
I, the Proposed Insured (and any Spouse or Owner signing below), by my signature set forth hereafter: **AGREE** to the following:

a. All Statements and answers in this application are complete and true to the best of my knowledge and belief.
b. Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is delivered while the health of any proposed insured continues, without material change, to be as represented in this application.
c. No agent has the authority to waive any answer or otherwise modify this application or to bind FCSU, hereinafter called "Society", in any way by making any promise or representation which is not set out in writing in this application.
d. $ _____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted.

Signed at (City/State): _____ Date: _____

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

_____ _____
Agent/Recommender Signature (Licensed Agent and # where required) Parent/Guardian Signature (required when Proposed Insured is under age 18)

_____ Approved by: _____
Print Agent Name Executive Secretary

AUTHORIZE any physician; medical practitioner; hospital; clinic; other medical or medically related facility; pharmacy benefits; manager; insurance support organization; pharmacy/government agency; insurance or reinsuring company; MIB, LLC. ("MIB"); consumer reporting agency; or any other organization; institution or person to give to FCSU or its reinsurer(s) all information it holds that pertains to medical consultations; treatments; surgeries; and hospital confinements which related to the physical and mental conditions of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize FCSU, or its reinsurers, to release any information including my personal health information obtained to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 24 months or the maximum length of time permitted by applicable law in the state where the policy is delivered or issued for delivery. I know that I or my representative may request a copy of this authorization.

It is understood that FCSU underwriters; claim examiners; reinsurers; attorneys or the medical director may disclose such health information to the parties for purposes of underwriting; compliance; record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed the recipient may re-disclose it resulting in loss of protections by federal regulations. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides; my authorization may not be revoked using a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by FCSU, or its reinsurer, (or FCSU or its reinsurers, becomes obligated to report such codes to MIB) while this authorization is in force. I may refuse to sign this authorization and that my refusal will affect my ability to obtain life insurance coverage.

FCSU IS LICENSED TO DO BUSINESS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN ANY STATE'S LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOWN 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 HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY.

INSURANCE FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Date: _____

_____ _____
Agent/Recommender Signature Proposed Insured Signature
Parent/Guardian Signature (required when Proposed Insured is under age 18)

J. AGENT'S STATEMENT

To the best of your knowledge and belief, will the insurance applied for replace or change any existing insurance or annuity? ☐ Yes ☐ No
If yes, any replacement regulations must be complied with.

Notice to Proposed Insured

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING MIB, LLC, ("MIB")
Information regarding your insurability will be treated as confidential. FCSU, or its Reinsurer(s) may, however, make a brief report thereon to MIB, a membership organization of life insurance companies which operates an information exchange on behalf of its members. If you 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 in its file. Upon receipt of a request from you, MIB will arrange disclosure of and information it may have in your file by calling (866) 692-6901 or you can go to their website www.mib.com. If you question the accuracy of information in MIB's file, you 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 is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

FCSU, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.