SERB NATIONAL FEDERATION *A Fraternal Benefit Society*

Application for Individual Life Insurance

PROPOSED INSURED: Is the Proposed Insured a member of Serb National Federation? ◯ Yes ◯ No. If not, applying for membership.

_____ _____ _____ _____ _____ - _____-_____
First Name MI Last Name Gender Phone Number

_____ _____ _____ _____ _____
Street Address City State Zip Code Email Address

_____ - _____ - _____ _____ - _____ - _____ _____ _____
Social Security Number Date of Birth Occupation Maiden Name if female Applicant

Owner: *(if different than Proposed Insured)* ☐ Check if owner is to remain after insured attains age 18.

_____ ____ _____ _____ _____ - _____-_____
First Name MI Last Name Gender Phone Number

_____ _____ _____ _____ _____
Street Address City State Zip Code Email Address

_____ - _____ - _____ _____ - _____ - _____ _____
Social Security Number Date of Birth Maiden Name if Female Owner

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Insurance Plan: _____ $_____ **Automatic Premium Loan Option**: ◯ Yes ◯ No
Plan Name Face Amount

Riders ☐ Accidental Death Benefit, ☐ Waiver of Premium, ☐ Term _____, ☐ Annuity _____ $_____

Premium Mode Frequency: ◯ Annual ◯ Semi-Annual ◯ Quarterly ◯ Monthly (EFT Authorization) ◯ Single

Dividend Election: ◯ Paid-Up Additions ◯ Reduce Premium ◯ Accumulate at Interest ◯ Cash

Does the Applicant have existing life insurance or annuity contracts with the Society or any other company? ◯ No ◯ Yes Will the insurance applied for replace or change any existing insurance or annuity? ◯ No ◯ Yes If Yes, Show the name of Company and Policy Number(s): _____

◯ **Beneficiary,** ◯ **Contingent** _____ _____ - _____ - _____
Name (first, Middle, Last) Social Security Number

____ - ____ - _____ _____ _____ _____
Date of Birth Address, City, State, Zip Relationship Share

◯ **Beneficiary,** ◯ **Contingent** _____ _____ - _____ - _____
Name (first, Middle, Last) Social Security Number

_____ - _____ - _____ _____ _____ _____
Date of Birth Address, City, State, Zip Relationship Share

◯ **Beneficiary,** ◯ **Contingent** _____ _____ - _____ - _____
Name (first, Middle, Last) Social Security Number

_____ - _____ - _____ _____ _____ _____
Date of Birth Address, City, State, Zip Relationship Share

◯ **Beneficiary,** ◯ **Contingent** _____ _____ - _____ - _____
Name (first, Middle, Last) Social Security Number

_____ - _____ - _____ _____ _____ _____
Date of Birth Address, City, State, Zip Relationship Share

PART II - INSURABILITY Height: _____ ft _____ in. Weight _____ lbs.

A. In the past 2 years, has the Proposed Insured:	YES	NO
1. Used tobacco in any form?	◯	◯
2. Flown as the pilot or crew member of any form of aircraft; or intend to do so within the next 2 years?	◯	◯
3. Had any license to drive suspended or revoked?	◯	◯
4. Engaged in skin/scuba diving; skydiving; parasailing; hang gliding; car; or motorcycle; or boat racing; or rodeo; or intend to do so within the next 2 years?	◯	◯

Details any Yes answer: _____

_____

B. In the past 5 years, has the Proposed Insured: received diagnosis or treatment from a physician; or, been confined in a medical care facility, for any of the following. (Circle any applicable condition.)

Cancer; tumor; or malignancy; diabetes; heart or circulatory disease or disorder; high blood pressure; kidney or urinary disease or disorder; lung or respiratory disease or disorder; epilepsy; mental or nervous disease or disorder; stroke; use of alcohol or non-prescription drugs; any disease or disorder of the stomach; intestines; gall bladder; liver; or rectum? ☐ No. ☐ Yes.

C. Has any person to be covered been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ No. ☐ Yes.

D. Has the Proposed Insured gained or lost weight (more than 10 pounds) in the Past Year? ☐ No. ☐ Yes.

E. Give details for any Yes answer above. Show: condition; dates; and name(s) and address (es) of physician(s); and medical care facilities._____

_____

(If additional space is needed, use a separate sheet; dated and signed.)

Family Physician: _____ _____ _____

Name Address Phone

Fraud Warning:

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.

Insured/Applicant Statement:

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 and true and accurately recorded; and (2) AGREES that this application shall be the basis for, and part of, any life insurance certificate issued; and (3) UNDERSTANDS that no agent or person, other than the President or Secretary of the Society, may: (a) change, modify or waive any of the printed statements herein; or (b) waive any of the rights or requirements of the Society. Such change. waiver or modification must be signed and in writing. No insurance will take effect unless and until: (1) this application is approved by the Serb National Federation; and (2) a certificate 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 unchanged.

AUTHORIZATION: The undersigned does hereby authorize 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 LLC); insurer; employer; institution; organization; or person, to provide such records or information to the Serb National Federation and its reinsurer; or, except for the MIB LLC, its legal representative. The Serb National Federation or its reinsurer may release any such records or information: to the MIB LLC; other insurers in which the Proposed Insured may have insurance; or to whom the Proposed Insured may apply for insurance; or to whom a claim may be submitted; or as may be lawfully required. Any records or information obtained will be treated as confidential and will only be used to determine eligibility for insurance or benefits. On request, the Serb National Federation will provide a copy of this Authorization. This Authorization shall be valid for a period of 24 months from the date shown below. This authorization may be revoked, by written notice, at any time prior to its expiry. A photocopy shall be as valid as the original.

Signed at _____ this _____ day of _____, 20_____

_____ _____ _____

Proposed Insured (Age 18 or older) Owner, if other than Proposed Insured Adult and/or Member Applicant

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. If Yes, any replacement regulations must be complied with.

_____ _____ _____ _____

Licensed Agent Name Licensed Agent Signature Licensed Agent Number Date

HOME OFFICE USE ONLY:
Lodge #: _____
Approved: _____