SERB NATIONAL FEDERATION (herein referred to as) SNF

Application for Life Insurance

Is the proposed Applicant a member of the SNF? ☐ Yes ☐ No. If No, applicant must apply for membership. _____
Lodge #

Type *(choose one)* - ☐ Permanent or ☐ *Term* - Face Amount $_____

Plan *(choose one)* - ☐ 20-Pay Life, ☐ Whole Life, ☐ Single Premium, ☐ *10-year R/C Term*, ☐ *Term to Age 30*

Rider Types *(choose those applicable)* - ☐ Annuity - $ _____ , ☐ Waiver of Premium, ☐ Accidental Death Benefit

☐ Automatic Premium Loan, ☐ Other _____

Premium Mode - ☐ Annual, ☐ Semi-Annual, ☐ Quarterly, ☐ Monthly *(Auto-Pay **ONLY**)* (Additional paperwork required)

Premium Paid with Application - $ _____

A. Proposed Insured:

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

Street Address _____ City _____ State _____ Zip Code _____ E-mail Address _____

Social Security Number _____ - _____ - _____ Date of Birth _____ - _____ - _____ City & State of Birth _____ , _____ Maiden Name if Applicant is Female _____

Occupation _____ Employer _____ Height ft. _____ Inches _____ Weight _____

B. Owner *(if different than Proposed Insured)*: _____
Relationship to Proposed Insured

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

Street Address _____ City _____ State _____ Zip Code _____ E-Mail Address _____

Social Security Number _____ - _____ - _____ Date of Birth _____ - _____ - _____ City & State of Birth _____ , _____ Maiden Name if Owner is Female _____

C. Beneficiary*(ies)*: - PRIMARY

Name (First, Middle, Last) _____ Relationship to Insured _____ Date of Birth _____ - _____ - _____ Social Security Number _____ - _____ - _____ Benefit Share _____%

☐ PRIMARY or ☐ Contingent

Name (First, Middle, Last) _____ Relationship to Insured _____ Date of Birth _____ - _____ - _____ Social Security Number _____ - _____ - _____ Benefit Share _____%

**** * If Additional Beneficiaries are desired, please attach an additional sheet to this application * ****

D. 1. Does the Proposed Insured have existing life insurance policies or annuity contracts? ☐ NO or, ☐ YES; If yes, provide details

Company	Year Issued	Face Amount	ADB	Medical Required (YES or NO)

2. Will the insurance applied for replace or change any existing life insurance policy or annuity contract of Proposed Insured?

☐ NO or, ☐ YES; If yes, provide details

Company Name _____ Year Issued _____ $ Face Amount _____ $ ADB _____ Medical required (Yes OR No) _____

3. Has the Proposed Insured applied for any other life/health insurance which is currently pending or awaiting issuance? ☐ NO or, ☐ YES

4. Has the Proposed Insured ever had an application for life/health insurance: declined, postponed, modified, rated, and/or had a policy canceled or limited, or its renewal/reinstatement refused? ☐ NO or, ☐ YES

If Yes is answered on the above questions, additional information is required in the comment section of this application and/or the appropriate replacement form completed.

E. Medical Information:

1. Family Physician (s): _____ _____ _____
   Name Address Phone

2. In the past 10 years, has the Proposed Insured received: care or treatment from a licensed medical practitioner; or been confined in a medical facility, for:

	Yes	No
a) lung disease; asthma; emphysema; pleurisy; pneumonia; chronic cough; or tuberculosis ?	☐	☐
b) eye; ear; nose; or throat; disease or disorder ?	☐	☐
c) high or low blood pressure; anemia; chest pain; rheumatic fever; heart disease or disorder; or other circulatory disease or disorder ?	☐	☐
d) diabetes; thyroid disease or disorder; or any disease or disorder of the glands—including blood?	☐	☐
e) disorder of the brain or nervous system; mental disorder; emotional disorder; dizziness; loss of consciousness; convulsions; or epilepsy ?	☐	☐
f) kidney stone; or any disease or disorder of the kidney, bladder, prostate, reproductive or genitorurinary disease or disorder ?	☐	☐
g) stomach ulcer; colitis; hernia; chronic indigestion; or any other disease of the stomach, intestines, rectum, gall bladder, liver ?	☐	☐
h) gout; arthritis; rheumatism; spine or back disease or disorder ?	☐	☐
i) cancer; tumor; malignancy; or abnormal growth of any kind ?	☐	☐
j) alcoholism or the use of alcohol; controlled substance use or addiction; drugs other than prescription drugs ?	☐	☐
k) sexually transmitted disease or disorder; syphilis, gonorrhea, hepatitis, venereal disease, or genital herpes ?	☐	☐
l) Acquired Immune Deficiency Syndrome (AIDS); or AIDS related complex ?	☐	☐
m) any surgical operation, scheduled or completed ?	☐	☐
n) any disease or disorder not listed above ?	☐	☐
o) been advised to have any diagnostic test, hospitalization, or surgery that was not completed ?	☐	☐
p) seen a doctor for a routine check-up, treatment, or consultation for any reason ?	☐	☐

F. Medical Information Details:

Question #	Condition	Date Treated	Degree of Recovery	Doctor/Facility	Address

G. Family History:

Family Members	*Father*	*Mother*	_____	_____
Living *or* Dead				
Age, if living *or* at death				
Health condition *or* cause of death				

H. Additional Information:

	Yes	No
1. In the past five (5) years has the Proposed Insured:		
a. flown, or intend to fly, as a pilot or crew member of any aircraft ?	☐	☐
b. engaged in any hazardous sport or activity, including but not limited to: skin/scuba diving, skydiving, parasailing, hang gliding, car, motorcycle or boat racing; or rodeo; or intend to do so ?	☐	☐
c. had his/her driver's license suspended or revoked; or been convicted of driving while under the influence of either alcohol or drugs ?	☐	☐
d. consumed alcoholic beverages ?	☐	☐
e. used narcotics or drugs ?	☐	☐
2. Do you currently use tobacco products ?	☐	☐
3. Have you ever used tobacco products ?	☐	☐

If so, what did you use ? _____ ; and When did you quit ? _____

Details: _____

_____

_____

Fraud Warnings

For your protection, various state laws, require the following statements to appear on this form.

For Residents of PA, & WV — 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 the person to criminal and civil penalties.

For Residents of OH — Any person who, with intent to defraud or knowing that he/she 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.

For Residents of IN - Any person who knowingly and with intent to defraud or deceive an insurer, files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Requirements Regarding Evidence of Date of Birth

Satisfactory evidence of the Date of Birth is required in all cases before premium payments may be made. It is preferable to have such evidence before issue. A certified copy of the Applicant's Birth Certificate is preferred. If this cannot be produced, the SNF will consider two (2) of the following documents along with a letter of explanation stating why they are being presented:

- State Issued Motor Vehicle Driver License/ID
- Certificate of Marriage
- Naturalization Record
- Passport (as long as it is at least five (5) years old).

If none of the above is available, a detailed statement as to the effort made to secure such evidence should be submitted with the application and further instructions as to the evidence for consideration will be given.

Producer's/Agent's Report

1. To the best of your knowledge, is insurance/annuity replacement involved in this transaction? ☐ YES or ☐ NO

2. Did you ask each question exactly as set forth in the application, and record the answers exactly as made? ☐ YES or ☐ NO

3. To the best of your knowledge, is this application for insurance/annuity intended to replace or change any existing insurance/annuity contract with any company?

☐ YES or ☐ NO

- ***If YES is answered to any of the above, the appropriate State Replacement Form/Notice must be submitted with this application.*** •

I acknowledge: except as provided in the Conditional Receipt, bearing the same date and payment as shown in this application, no insurance will take effect unless and until:

(1) this application is approved by the SNF
(2) a policy of life insurance is issued; and
(3) the full premium is paid.

All such conditions must be met while the health and other factors affecting insurability of the Proposed Insured remain as described in this application.

I hereby represent that the statements and answers included herein are full, complete, and true, to the best of my knowledge and belief. I agree that this application shall be the basis for and a part of any contract issued. I understand that only the President or the Secretary of the Federation (in writing) may: (1) make or modify contracts; or (2) waive any of its rights or requirements.

Signed at: _____ (City), _____ (State) on this _____ (Date) day of _____ (Month), _____ (Year).

_____ PRINTED name of Proposed Insured

_____ PRINTED name of Signature of Producer/Agent _____ Lodge #

_____ Signature of Proposed Insured ***(if age 18 or older)***

_____ Signature of Producer/Agent _____ Lic. #

_____ PRINTED name of Adult and/or Member Applicant ***(if Proposed Insured's age is < 18)***

_____ PRINTED name of Owner (*if other than the Proposed Insured*)

_____ Signature of Adult and/or Member Applicant (***if Proposed Insured' age is < 18***)

_____ Signature of Owner (*if other than the Proposed Insured*)

Information Disclosure - Authorization

Thank you for your recent life insurance application.

A. During our underwriting process, a consumer investigation report may be obtained that may contain information concerning personal characteristics, mode of living, and/or general reputation. This information may be obtained through personal interviews of your acquaintances, neighbors, and/or friends. Further information, as to the scope of these inquiries, can be provided to you upon a written request to the SNF Home Office.

B. Any information with respect to the underwriting process of your application will be treated as confidential. However, we can make a report to the MIB Inc., (MIB is a not-for-profit membership organization of life insurance companies that operates an information exchange in behalf of its members). If an application is made to another MIB member for either life or health insurance coverage; or submitted a claim for benefits to a MIB member; the MIB (upon request) will supply the MIB member with the information it has on file. The MIB, upon written request from you, will arrange disclosure of any information it may have in your file (medical information will only be disclosed to your attending physician). If you suspect the accuracy of this information is incorrect, you may contact the MIB to seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, phone 866-692-6901. We may also release information in our file to other life insurance companies and/or our reinsurer(s) to whom application may be made for life and/or health coverage; or to whom a claim for benefits may be submitted.

THIS NOTIFICATION MUST BE GIVEN TO THE PROPOSED INSURED BEFORE THE APPLICATION IS COMPLETED.

_____ _____

Signature of Recruiter/Agent Date

I Authorize the following that may have any records and/or information regarding me or my minor children, including driving records, controlled substance and/or alcohol use, to provide these records of information to: SNF; its legal representative, or its reinsurers:

- Any licensed physician or medical practitioner
- Any hospital or clinic, medical or medically related facility
- The MIB Inc., consumer reporting agency or other such organization, insurer, or reinsurer, employer, institution, government agency, or person

I also Authorize that:

- All sources stated above expect the MIB to provide such information to a consumer reporting agency or other agency employed by the SNF to obtain such information.
- The SNF or its reinsurers, to release such information to the MIB, other insurers wherein my minor children and/or myself have insurance, to whom I or they may apply for insurance, or to whom a claim may be submitted; or as may be required by law.
- The SNF to obtain an investigative consumer report.

I Understand that:

- Upon request, I or my duly authorized representative may receive a copy of the authorization
- The information obtained by this authorization will be used to determine my eligibility and/or my minor children's eligibility for insurance, or to determine the eligibility for benefits in the event of a claim.
- Any information obtained on the application about a medical consultation or informational visit concerning AIDS or ARC, as opposed to the diagnosis or treatment of AIDS or ARC, will never be used to underwrite coverage on a proposed insured.

I Agree that this authorization or a copy shall be valid for a period of 30 months ***(if written in the state of INDIANA 24 months)*** from the date signed below.

Home Office Copy

_____ _____

Signature of Proposed Insured ***(if age 18 or older)*** Date

_____ _____

Signature of Adult and/or Member Applicant (***if Proposed Insured's age is < 18***) Date

_____ _____

Signature of Owner (*if other than the Proposed Insured*) Date

_____ _____

Witness - Producer/Agent Date

Information Disclosure - Authorization

Thank you for your recent life insurance application.

A. During our underwriting process, a consumer investigation report may be obtained that may contain information concerning personal characteristics, mode of living, and/or general reputation. This information may be obtained through personal interviews of your acquaintances, neighbors, and/or friends. Further information, as to the scope of these inquiries, can be provided to you upon a written request to the SNF Home Office.

B. Any information with respect to the underwriting process of your application will be treated as confidential. However, we can make a report to the MIB Inc., (MIB is a not-for-profit membership organization of life insurance companies that operates an information exchange in behalf of its members). If an application is made to another MIB member for either life or health insurance coverage; or submitted a claim for benefits to a MIB member; the MIB (upon request) will supply the MIB member with the information it has on file. The MIB, upon written request from you, will arrange disclosure of any information it may have in your file (medical information will only be disclosed to your attending physician). If you suspect the accuracy of this information is incorrect, you may contact the MIB to seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, phone 866-692-6901. We may also release information in our file to other life insurance companies and/or our reinsurer(s) to whom application may be made for life and/or health coverage; or to whom a claim for benefits may be submitted.

THIS NOTIFICATION MUST BE GIVEN TO THE PROPOSED INSURED BEFORE THE APPLICATION IS COMPLETED.

_____ _____

Signature of Recruiter/Agent Date

I Authorize the following that may have any records and/or information regarding me or my minor children, including driving records, controlled substance and/or alcohol use, to provide these records of information to: SNF; its legal representative, or its reinsurers:

- Any licensed physician or medical practitioner
- Any hospital or clinic, medical or medically related facility
- The MIB Inc., consumer reporting agency or other such organization, insurer, or reinsurer, employer, institution, government agency, or person

I also Authorize that:

- All sources stated above expect the MIB to provide such information to a consumer reporting agency or other agency employed by the SNF to obtain such information.
- The SNF or its reinsurers, to release such information to the MIB, other insurers wherein my minor children and/or myself have insurance, to whom I or they may apply for insurance, or to whom a claim may be submitted; or as may be required by law.
- The SNF to obtain an investigative consumer report.

I Understand that:

- Upon request, I or my duly authorized representative may receive a copy of the authorization
- The information obtained by this authorization will be used to determine my eligibility and/or my minor children's eligibility for insurance, or to determine the eligibility for benefits in the event of a claim.
- Any information obtained on the application about a medical consultation or informational visit concerning AIDS or ARC, as opposed to the diagnosis or treatment of AIDS or ARC, will never be used to underwrite coverage on a proposed insured.

I Agree that this authorization or a copy shall be valid for a period of 30 months ***(If written in the state of INDIANA 24 months)*** from the date signed below.

Proposed Insured Copy

_____ _____

Signature of Proposed Insured ***(if age 18 or older)*** Date

_____ _____

Signature of Adult and/or Member Applicant (***if Proposed Insured's age is < 18***) Date

_____ _____

Signature of Owner (*if other than the Proposed Insured*) Date

_____ _____

Witness - Producer/Agent Date

Life Insurance - Conditional Receipt

Received from:_____ the sum of $_____ in connection with a life insurance application

bearing the same date as this receipt; for _____ (Proposed Insured). This receipt is not valid unless:

No insurance shall be effective prior to policy delivery unless each and every condition specified in paragraph 'A' below are satisfied exactly with no exceptions.

A. Conditions in which insurance may become effective prior to policy delivery.

1. If the amount of the payment taken with the application for life insurance is sufficient to pay the first mode premium selected at application; AND
2. If all medical examinations, tests, X-Rays, ECG/EKG initially required by the SNF are completed and received within sixty (60) days from the date of the application; AND
3. Any part of the life insurance application or this conditional receipt contains no misrepresentation: AND
4. If the Proposed Insured(s) [and the Applicant if Payor Benefits are applied for] is (are) acceptable under SNF rules, limits, and standards for the plan and for the amount applied for without modification and at the rate of premium paid; then insurance will be effective for the latest of:
    a. the date of the application; OR
    b. the last date of any medical examinations, tests, X-Rays, or ECG/EKG, initially required by the SNF.

B. Maximum Amount of Insurance that may become effective prior to policy delivery shall not exceed the lessor of:

1. the amount applied for; OR
2. $100,000 - inclusive of the life insurance currently in-force with the SNF including any benefits payable as a result of the accidental death of the proposed insured.

C. Return of Payment: If one or more of these conditions outlined in paragraph 'A" have not been satisfied exactly, there shall be no liability on the part of the SNF except to return the applicable premium payment.

_____ _____

Signature of Producer/Agent Date