SERB NATIONAL FEDERATION - A FRATERNAL BENEFIT SOCIETY

Application for Individual Life Insurance

Proposed Insured: (Complete in all cases. This person will be the Policy Owner unless the Owner section is completed.)

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

Street Address ____ City ____ State ____ Zip Code ____ Email Address ____

Social Security Number ____ - ____ - ____ Date of Birth ____ - ____ - ____ Occupation ____ Name of Employer ____

Employer Street Address ____ City ____ State ____ Zip Code ____ Phone Number ____ - ____ - ____

Owner: (Complete for Proposed Insured 17 years of age and under; for adults only if other than the Proposed Insured above)

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

Street Address ____ City ____ State ____ Zip Code ____ Relationship ____

Social Security Number ____ - ____ - ____ Date of Birth ____ - ____ - ____ Entity Name ____ Tax ID # ____ - ____

Beneficiary Information:

○ **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 ____

Trust as Beneficiary: (Complete Verification of Trust Form if section b is completed below)

	Primary	Contingent
a) Trust under the Insured's last will	○	○
b) Trust Name ____ Trust Dated ____ - ____ - ____ as amended	○	○

Insurance Coverage:

Insurance Plan: ____ (Plan Name) $____ (Face Amount) **Automatic Premium Loan Option**: ○ Yes, ○ No.

Riders: ☐ Accidental Death Benefit, ☐ Term ____, $____ ☐ Annuity ____ $____

Premium Mode Frequency: ○ Annual, ○ Semi Annual, ○ Quarterly, ○ Monthly (EFT Authorization), ○ Single

Payor (If other than applicant): ____

Dividend Election: ○ Paid-Up Additions, ○ Reduced Premium, ○ Accumulate at Interest, ○ Cash.

Replacement:

a) Does the applicant have existing life insurance or annuity contracts with any company? ○ Yes, ○ No.

b) Will the life insurance now applied for replace or change any existing insurance or annuity? ○ Yes, ○ No.

If yes, you must complete and submit a Replacement Form.

General Information:

	Yes	No
1) **Foreign Travel, Aviation, and Military:**		
a) Does any person to be covered intend to travel outside the U.S. or Canada within two years?	☐	☐
b) Except as a passenger on a regularly scheduled flight; does any person to be covered intend to fly within the next two years; or has he/she flown during the past two years?	☐	☐
c) Is any person to be covered a member of the Armed Forces or entered into a written agreement to become a member of the Armed Forces (including the National Guard)?	☐	☐
2) **Avocation and Sports:** In the past three years, has any person to be covered participated in any form of racing, skin or scuba diving, parachuting, hang gliding, or rock climbing? Remarks: Give details for any question answered Yes. Identify the person affected. _____	☐	☐
_____		
3) **Driving Information:**		
a) Driver's License: Number _____ State _____		
b) Has any Proposed Insured been convicted with any moving violation; or accident at fault within the last 5 years?	☐	☐
4) **Other Insurance:**		
a) Does any person to be covered have an existing life insurance or annuity contracts with the company or any other company?	☐	☐
b) Has any company declined to issue; renew, or reinstate; rated, modified; postponed; or canceled any life or health insurance on any person covered?	☐	☐
c) Will insurance, including annuities, in any company, be discontinued or changed; or subject to borrowing of cash value; if the insurance applied for is issued?	☐	☐
d) Is any application for life or health insurance on any person to be covered pending in any other company?	☐	☐
5) **Annual Income Information**: Proposed Insured: $ _____ Other/Spouse: $ _____		

Personal Measurements: Height: _____ feet _____inches. Weight:_____ Pounds.

Medical Information:

	Yes	No
1) During the past five years, has any person to be covered been examined or prescribed medication by a physician or a member of the medical profession?	☐	☐
2) Has any person to be covered ever been treated for, or been diagnosed by a physician as having:		
a) Cancer; diabetes; or high blood pressure?	☐	☐
b) Disease or disorder of the heart or blood?	☐	☐
c) Nervous or mental condition; or any disease or abnormality of the brain or nervous system?	☐	☐
d) Any disease or abnormality of the lungs or respiratory system?	☐	☐
e) Disease or abnormality of the kidneys; liver; prostrate or genitourinary system?	☐	☐
f) Disease or abnormality of the gastrointestinal system?	☐	☐
g) Disorder of the muscles; bones; or joints?	☐	☐
3) Has any person to be covered ever been advised by a physician to seek medical treatment or counseling, been treated for or received counseling, or joined a support group for the use of alcohol?	☐	☐
4) Has any person to be covered ever been diagnosed by a member of the of the medical profession; or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
5) During the last 5 years has any person to be covered been hospitalized or had surgery of any kind?	☐	☐
6) Has any person to be covered:		
a) Other than a onetime or experimental basis; used barbiturates; heroin; cocaine; marijuana; or any illegal; restricted or controlled substance; except as prescribed by a physician?	☐	☐
b) Been advised by a physician to seek; or received medical treatment for drug use; or been convicted for drug use or pled guilty to charges of drug use or distribution?	☐	☐
7) Has any person to be covered used any nicotine products (cigarettes; cigars; chewing tobacco; pipe; nicotine gum patch; or other)		
a) In the past 12 months?	☐	☐
b) In the past 36 months?	☐	☐
8) Is any person to be covered pregnant? (If yes; indicate anticipated date of delivery) _____	☐	☐
9) Is any medication currently prescribed for any person to be covered? _____ (If Yes; name them and for whom they are prescribed.)	☐	☐
10) Has any person to be covered 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?	☐	☐

b) Die from cardiovascular disease below age 60? ☐ ☐

Give Details for all "Yes" answers: (If additional space id needed, use a separate sheet, date, and sign.)

Quest#	Dates	Medical Condition	Name of Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Name of Doctor	Address	Reason for Last Doctor Visit	Phone Number
_____	_____	_____	(_____) _____-_____
_____	_____	_____	(_____) _____-_____
_____	_____	_____	(_____) _____-_____
_____	_____	_____	(_____) _____-_____

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.

AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT–Serb National Federation

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 Serb National Federation. I, the Primary 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 authority to waive any answer or otherwise modify this application or to bind Serb National Federation, hereinafter called "Company", 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.

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

During our underwriting process, a consumer investigation may be obtained that may contain information concerning personal characteristics., made 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 Life Home Office.

Any information with respect to the underwriting process of your application will be treated as confidential. However, we can make a report to MIB LLC, (MIB), (MIB is a 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. If you suspect the accuracy of this information is incorrect, you may contact 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. Information for consumers may also be obtained on its website at www.mib.com. 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.

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 the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition 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 authorize Serb National Federation or its reinsurers to make a brief report of my personal health information to MIB. I further authorize the Company, 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 the maximum length of time permitted by applicable law in the state where the policy/certificate is delivered or issued for delivery. I know that I or my representative may request a copy of this authorization.

It is understood that Serb National Federation 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 redisclose it resulting in loss of protection 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 during 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 the Company, or its reinsurer, (or the Company, 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 to sign will affect my ability to obtain life insurance coverage.

ACKNOWLEDGE receipt of the following notices:

a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and
b) MIB Pre-Notice

SERB NATIONAL FEDERATION 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.

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.

_____ #_____ _____ / _____ / _____

Witness (Licensed Agent and Number) Date

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