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

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 a member of the medical profession ever diagnosed any person to be covered as having; or treated any applicant for AIDS (Acquired Immune Deficiency Syndrome); or ARC (Aids Related Complex)? ◯ No. ◯ Yes.

D. Has the Proposed Insured gained or lost weight 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 presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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. The time limit of this authorization shall comply with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. This authorization may be revoked, by written notice, at any time prior to its expiry. A photocopy shall be as valid as the original.

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 where required) Date

HOME OFFICE USE ONLY:
Lodge #:
_____