Give your children the financial start they deserve!

Are you concerned about your children's financial future?
Would you apply now for something that could provide your children or grandchildren with a lifetime value – a whole life insurance plan with a low childhood premium of $10 per month?

THAT'S ONLY 33 CENTS PER DAY.

The premium will never increase and is payable for 10 years ONLY.
This is whole life insurance coverage that lasts a lifetime.

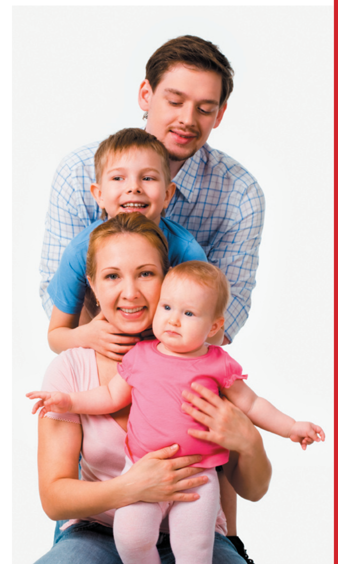
The plan builds up CASH VALUE and gives automatic membership in the Polish Women's Alliance of America.

For details please call
1-888-522-1898 ext 228 and ask for BO PADOWSKI

For $10 per month, we will issue a whole life insurance policy with FACE AMOUNTS as follows:

No medical exam is required.

MALE		FEMALE	
Age	**Face Amount**	**Age**	**Face Amount**
0*	$9,443.54	0	$11,219.92
1	$9,155.76	1	$10,859.44
2	$8,855.90	2	$10,480.62
3	$8,547.95	3	$10,114.71
4	$8,243.90	4	$9,750.00
5	$7,945.15	5	$9,399.77
6	$7,652.83	6	$9,063.69
7	$7,381.26	7	$8,731.97
8	$7,109.55	8	$8,423.68
9	$6,851.35	9	$8,120.12
10	$6,600.49	10	$7,822.57
11	$6,362.35	11	$7,546.05
12	$6,131.52	12	$7,275.34
13	$5,912.54	13	$7,017.30
14	$5,708.66	14	$6,765.64
15	$5,514.62	15	$6,531.40
16	$5,329.83	16	$6,303.03
17	$5,157.02	17	$6,080.96



For children from newborn to 17 years old
(Premium is calculated to the nearest birthday)
*** Up to six months.**

Fill out the application on the back and mail it with your applicable premium payment payable to *Polish Women's Alliance* to:

Polish Women's Alliance of America
6643 N. Northwest Hwy. 2nd Floor
Chicago, IL 60631-1360

To apply, simply answer a few questions on our application and return it to the Home Office with the first premium payment of $10.

If you decide to pay annually, please submit $111.12 (a savings of $8.88).
If you want to pay one lump sum or need more information – call the Home Office at 1-888-522-1898 ext 228.

Issue a check or money order for either $10 or $111.12 made payable to the ***Polish Women's Alliance of America*** or complete the Credit Card Authorization information below.

CREDIT CARD AUTHORIZATION:

Please charge my one-time premium in the amount of $____________ to my ___VISA ___ Master Card or ___ Discover

Name on credit card | *Card Number* | *Exp. Date*

Signature | *Billing Address* | *Zip Code*

Plan applied for (Write Plan Name): ____ Face Amount: ____ Premium Mode (Check one): Ann ☐ S-Ann ☐ Quar ☐ Mo ☐ Single ☐	APPLICATION FOR LIFE INSURANCE With **POLISH WOMEN'S ALLIANCE OF AMERICA** 6643 N Northwest Highway, 2nd Floor Chicago, IL 60631	Office Use Only Group No.____ Certificate No.____ Plan No.____ Amount of Insurance____

1. Name of Proposed Insured			2. Residence Address
3. Sex Male ☐ Female ☐	4. Date of Birth (Mo) (Day) (Yr)	5. Age	City State Zip
6. Height Weight	7. Place of Birth		8. Telephone Number Home Work
9. Marital Status (Check One) Single ☐ Married ☐ Widowed ☐ Divorced ☐	10. If female, and ever married, give maiden name		11. Social Security No.
12. Occupation	13. Name and Address of Employer		

14. Beneficiary
Name ____ Relationship____

Address____ City____ State____ Zip____

15. Contingent Beneficiary
Name____ Relationship____

Address____ City____ State____ Zip____

DECLARATION OF INSURABILITY

		Yes	No
1.	Within the past 3 years, has the proposed insured used tobacco in any form?	☐	☐
2.	Within the past 3 years has the proposed insured ever had or been treated for:		
a.	Disease or disorder of heart, kidneys, stomach, liver, lungs, bones or joints?	☐	☐
b.	Epilepsy, convulsion, dizziness, fainting, stroke or mental disorder?	☐	☐
c.	High blood pressure, chest pain, diabetes, cancer or tumor?	☐	☐
d.	Alcoholism, alcohol abuse or drug abuse?	☐	☐
e.	Any other physical disease or deformity or consulted or been examined by any physician for other than a symptom-free check-up, or had an electrocardiogram, x-rays, or blood studies during the past 3 years?	☐	☐
3.	Has any application for life insurance on the proposed insured been declined, withdrawn, postponed, or modified in any way by any insurance company during the past 3 years?	☐	☐

A. Is the insurance intended to replace or change any insurance now in force? ☐ Yes ☐ No
B. What is the total amount of life insurance inforce on the life of the proposed insured?____
C. What is the total amount of life insurance inforce on the life of the applicant, if other than the proposed insured?____
D. Is the applicant a member of the Polish Women's Alliance? ☐ Yes ☐ No
E. Select dividend option: ☐ left on deposit ☐ cash ☐ purchase paid up additions

Information in this application is given to obtain this insurance and is true and complete to the best of my knowledge and belief. This certificate shall not take effect unless the first or single premium is actually paid to the Alliance at the time of application.

Signature of Proposed Insured____

Signature of Applicant, if other than Proposed Insured____

Signature of Witness or Agent____

Full Amount Attached $____ Signed at (City, State)____ Date____

Fill out the application above and mail it with your applicable premium payment payable to *Polish Women's Alliance* to:

Polish Women's Alliance of America
6643 N. Northwest Hwy. 2nd Floor
Chicago, IL 60631- 1360

Any questions? Need help? Call toll free at
1-888-522-1898 ext 228

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