POLISH WOMEN'S ALLIANCE OF AMERICA
A Fraternal Benefit Society
6643 N. Northwest Hwy, 2nd Fl Chicago, IL 60631

LIFE INSURANCE, APPLICATION

Please Print, Use Dark Ink

---

1. **PROPOSED INSURED:** ☐ Female ☐ Male
 a. Name:______________________________ (First - Mi - Last)
 b. Date of Birth:____________ (Mo – Day – Yr) Place of Birth:____________ (State/Country)
 c. Height:______ Weight:______ Soc. Sec. No.:____________ Tel. No.:____________
 d. Occupation:______________________________ How Long:________
 e. Member of Polish Women's Alliance of America: ☐ Yes. ☐ No. If no, apply for membership.

---

2. **PLAN**:______________________________ Face Amount:____________
 a. Riders: ☐ None. ☐ ADB, amount: $____________ ☐ Other:____________
 b. Premium Mode: ☐ Ann. ☐ S-Ann. ☐ Quar. ☐ Mo. Amount paid with this application:____________
 c. Dividend Option: ☐ Cash. ☐ Reduce Premium. ☐ Paid-Up Additions. ☐ Accumulate.

---

3. **OWNER**: ☐ Proposed Insured. ☐ Other, show: name: ____________
 Relationship: ____________, Soc. Sec. No.: ____________
 Address: ______________________________

---

4. **BENEFICIARY**: (Show: full name; date of birth; relationship; and, share.)
 Primary: ______________________________
 Contingent: ______________________________

---

5. In the past 3 years, has the Proposed Insured:
 a. Used tobacco in any form: ☐ No. ☐ Yes.
 b. Engaged in: scuba or sky diving; or, boat, car or motorcycle racing: ☐ No. ☐ Yes.
 c. Flown as the pilot or crewmember of any form of aircraft: ☐ No. ☐ Yes.
 d. Had any license to drive suspended or revoked: ☐ No. ☐ Yes.
 e. Details any Yes answer: ______________________________
 ______________________________ (If additional space is needed, use separate sheet, dated and signed.)

---

6. a. In the past 5 years, has the Proposed Insured: been diagnosed or treated by a physician; or, been confined in a medical care facility, for: (Circle any applicable condition.)
 (1) cancer, tumor or malignancy; diabetes; heart or circulatory disease or disorder; high blood pressure; kidney or genito-urinary disease or disorder; lung or respiratory disease or disorder; epilepsy or mental or nervous disease or disorder; stroke; any disease or disorder of the stomach, intestines, gall bladder, liver or rectum:
 ☐ No. ☐ Yes.
 (2) any disease or disorder not listed above or any surgical operation scheduled or contemplated:
 ☐ No. ☐ Yes.
 b. In the past 5 years, has the Proposed Insured: 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 inflection:: ☐ No. ☐ Yes.
 c. Details, any Yes answer in a or b above. Show: condition; dates; and name(s) and address(s) of physician(s) and medical care facilities.
 ____
 ____
 ______________________________(If additional space is needed, use separate sheet, dated and signed.)

---

7. Will the insurance applied for replace or change any existing insurance or annuity? ☐ No. ☐ Yes.; show name of insurer(s) and contract number(s):______________________________
 ____

(Continued on Reverse)

8. **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.

---

9. **Special Requests:**

---

* * * * *

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, true and accurately recorded; (2) **AGREES** that this application shall be the basis for and a part of any life insurance contract issued; and (3) **UNDERSTANDS** that no agent or person other than an executive officer of Polish Women's Alliance of America may, in writing: (a) change, modify or waive any of the printed statements herein; or (b) waive any of the rights or requirements of the Polish Women's Alliance of America.

Except as may be provided in a Conditional Receipt, bearing the same date and payment amount as shown in this application, no insurance shall take effect unless and until: (1) this application is approved by the Polish Women's Alliance of America; (2) a contract 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 as described in this application.

AUTHORIZATION. The undersigned hereby authorizes 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); consumer reporting agency; insurer; employer; institution; organization; or, person,

to provide such records or information to: the Polish Women's Alliance of America; its reinsurer; or, except for the MIB, its legal representative. The Polish Women's Alliance of America or its reinsurer may release any such records or information: to the MIB; to other insurers in which the Proposed Insured may have insurance, to whom the Proposed Insured may apply for insurance or to whom a claim may be submitted; or, as may be lawfully required. The Polish Women's Alliance of America may, at its discretion, obtain an investigative consumer report. Any records or information obtained will: be treated as confidential; and, be used to determine eligibility for insurance or benefits.

On request, the Polish Women's Alliance of America will provide a copy of this Authorization. This Authorization shall be valid for a period of 24 months from the date shown below. A photocopy shall be valid as the original.

Signed at:____ this ______ day of__________________, 20____

____
Proposed Insured (Age 18 or older)

____
Adult or Member Applicant or Owner, if other than Proposed Insured

____
Witness (licensed agent where required)

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.

For Home Office Use: Certificate No.:____________________________ Group No.______________________

POLISH WOMEN'S ALLIANCE OF AMERICA
A Fraternal Benefit Society

APPLICATION SUPPLEMENT – FLORIDA

Each Applicant for a life insurance certificate has the right to name a Secondary Addressee. The Secondary Addressee will receive a notice of any past due premium and possible lapse in the life insurance coverage.

☐ **SECONDARY ADDRESSEE**. Name: ______________________________

Address: ______________________________

____

☐ I choose not to name a Secondary Addressee.

* * * * *

Date: ____________ ______________________________ ______________________________

Applicant's Signature Agent's Signature

Agent's Name, print: ______________________________ Florida License I.D. No.: ____________

Form LA/AA-0900