



8. **Special Requests:**

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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. \_\_\_\_\_

LA-0900

NY

**THIS RECEIPT DOES NOT PROVIDE INSURANCE UNTIL ITS CONDITIONS ARE MET**

Received from: \_\_\_\_\_ in connection with an application on the life of: \_\_\_\_\_, the sum of: \$ \_\_\_\_\_.  
Date: \_\_\_\_\_ Agent: \_\_\_\_\_

Provided the following conditions are met, exactly, the insurance applied for will be effective on the later of: (1) the date of the application; or (2) the last date of any initially required test(s) or examination(s); or (3) an effective date requested in the application.

1. The Proposed Insured is found to be a standard risk for the amount and plan applied for in accordance with our underwriting rules then in effect.
2. The amount paid is sufficient to pay the first mode premium for the amount and plan applied for including any Riders.
3. The amount paid is good and collectible.

**Maximum Amount.** The maximum amount of insurance which may become effective under this Conditional Receipt is \$50,000. The maximum amount shall include: (1) any accidental death benefits applied for; and (2) any other pending application for the Proposed Insured.

Please contact the Polish Women's Alliance of America if you do not, within 60 days from the date of this Conditional Receipt, receive: the life insurance certificate applied for; or, a refund of the amount paid. Please include: the name of the agent; and, the date and amount paid.

**Do not pay in cash. All remittances should be payable to PWAA. Do not make payable to the agent or leave the payee blank.**

Form LA-0900-CR

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Polish Women's Alliance of America (PWAA)  
(Detach and give to Applicant)

**CONSUMER REPORT**

**Notice, Part 1**

This notice is to inform you that PWAA may obtain an investigative consumer report. If obtained, the report will include information obtained through personal interviews with third parties such as: financial sources; business associates; family members; friends; neighbors; or, others with whom you are acquainted. The report may include information as to your: character; general reputation; personal characteristics; and, mode of living. You may, within a reasonable period of time, request, in writing, detailed information regarding the nature and scope of any such report. You may, on request, receive a copy of any such report.

Form LA-0900-NY

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Polish Women's Alliance of America (PWAA)  
(Detach and give to Applicant)

**MEDICAL INFORMATION BUREAU (MIB)**

**Notice, Part 2**

Information regarding your insurability will be treated as confidential. PWAA's reinsurer may, however, make a brief report thereon to the MIB, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member for life or health insurance coverage, or if a claim for benefits is submitted to such member, the MIB will, upon request, supply such member with the information it may have in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the MIB file information, you may contact the MIB and seek a correction in accordance with procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is: Box 105, Essex Station, Boston, Massachusetts 02112; telephone: (617) 426-3660.

Form LA-0900

**POLISH WOMEN'S ALLIANCE OF AMERICA**  
A Fraternal Benefit Society

**APPLICATION SUPPLEMENT**  
(New York)

This Application Supplement is to be completed and submitted with the Application only when: (1) the Proposed Insured is under age 15; and (2) the Application is written in the State of New York.

1. Proposed Insured, amount of in-force life insurance (if none, state "none"): \_\_\_\_\_
2. Applicant, relationship to Proposed Insured: \_\_\_\_\_  
amount of in-force life insurance (if none, state "none"): \_\_\_\_\_

Dated and signed at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Applicant: \_\_\_\_\_

Witness (Agent): \_\_\_\_\_

LA-0900-SNY