

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, 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 \_\_\_\_\_ 5. Age \_\_\_\_\_  
   
 (Mo) (Day) (Yr) City State Zip  
 6. Height Weight 7. Place of Birth 8. Telephone Number  
 Home Work  
 9. Marital Status (Check One) 10. If female, and ever married, give maiden name 11. Social Security No.  
 Single Married Widowed Divorced  
     
 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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
b. Epilepsy, convulsion, dizziness, fainting, stroke or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c. High blood pressure, chest pain, diabetes, cancer or tumor?	<input type="checkbox"/>	<input type="checkbox"/>
d. Alcoholism, alcohol abuse or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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 Has any application for life insurance on the proposed insured been declined, withdrawn, postponed, or modified in any way by any insurance company during the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>

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 \_\_\_\_\_

**CREDIT CARD AUTHORIZATION:**

Please charge my one-time premium in the amount of \$ \_\_\_\_\_ to my  
 \_\_\_\_\_ Visa \_\_\_\_\_ Master Card or \_\_\_\_\_ Discover

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*Name on credit card* \_\_\_\_\_ *Card Number* \_\_\_\_\_ *Exp. Date* \_\_\_\_\_

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*Signature* \_\_\_\_\_ *Billing Address* \_\_\_\_\_ *Zip Code* \_\_\_\_\_