INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠

A Fraternal Benefit Society

Application for Term Insurance

PART 1

SECTION 1 – Proposed Insured

Name ______________________________ Street ______________________________

City ______________________________ State ______ ZIP __________ Years at this address* ________

SSN/Tax ID ______________________________ *If less than 3 yrs., add prior residence address in additional info, pg 4.

Phone number ( ) ______________________ Marital status ❑ S ❑ M ❑ W ❑ D Sex ❑ M ❑ F

❑ U.S. driver's license ❑ Green Card ❑ Passport DOB __________ State/Country of birth __________

❑ Other ______________________________ Annual income $ ______________________________

ID number ______________ ID issuer ______________ Employer's name ______________________________

ID issue date ______________ ID expiration date ______________ Position/Title ______________________________

E-mail address ______________________________ Duties ______________________ Length of employment ______

Are you a U.S. citizen? ❑ Yes ❑ No If No, are you a legal U.S. resident? ❑ Yes ❑ No

SECTION 2 – Other Insurance

1. EXISTING or APPLIED FOR INSURANCE

Does the Proposed Insured have any existing or applied for life insurance (L) or annuity (A) contracts with this or any other company? ❑ Yes ❑ No

IF YES, complete and submit state replacement forms, if required, with this application.

Provide details:

Company	Type (L, A)	Amount of Insurance	Year of Issue	Accidental Death Amount	Existing or Applied for
					❑ E ❑ A
					❑ E ❑ A

2. REPLACEMENT

In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? ❑ Yes ❑ No

If Yes, complete and submit a replacement questionnaire **AND** any other state required replacement forms with this application.

SECTION 3 – Ownership (Complete if Owner is other than Proposed Insured)

1. OWNER other than PROPOSED INSURED

Name ______________________________ SSN/Tax ID ______________________________

Street ______________________________ Phone number ( ) ______________ DOB __________

City ______________ State ______ ZIP ______ Relationship to Proposed Insured ______________________________

❑ U.S. driver's license ❑ Green Card ❑ Passport E-mail address ______________________________

❑ Other ______________________________

ID number ______________ ID issuer ______________

ID issue date ______________ ID expiration date ______________

❑ Check if you wish ownership to revert to Insured upon Owner's death.

There may be tax consequences, please consult your tax advisor.

If you need more space, please use the additional information section on page 4.

SECTION 4 – Beneficiary(ies)

Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.

❑ **PRIMARY**

Name ______________________________

Street ______________________________

City ____________________ State ______ ZIP ______

DOB __________ SSN/Tax ID ____________________

Relationship to Proposed Insured ____________________

Percent of proceeds ______________%

❑ **PRIMARY** ❑ **CONTINGENT**

Name ______________________________

Street ______________________________

City ____________________ State ______ ZIP ______

DOB __________ SSN/Tax ID ____________________

Relationship to Proposed Insured ____________________

Percent of proceeds ______________%

SECTION 5 – Information Regarding Insurance Applied for

1. PRODUCT & FACE AMOUNT

Product name ______________________________ Plan ❑ 10-yr. ❑ 20-yr. ❑ 30-yr. ❑ Other ____________

Face amount $____________ OR Income Replacement Benefit Payment Amount $____________ # of payments______

Number of months for initial lump sum ________ (1-6 months)

Riders/Benefits: ❑ Accelerated Death Benefit ❑ Premium Waiver Disability ❑ Return of Premium ❑ Other ____________

SECTION 6 – Payment Information

If **Electronic Payment** is chosen, complete Pre-Authorized Collection (PAC) form on page 7.

1. PAYMENT MODE *(Check one)*

Direct bill: ❑ Annual ❑ Semi-Annual ❑ Quarterly

Electronic payment: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly

❑ Payment with app $________ ❑ Draft first payment

Additional details ______________________________

2. BILLING ADDRESS INFORMATION

❑ Proposed Insured's address ❑ Primary Owner's address

❑ Other Premium Payor's/Alternate billing address *(details below)*

Name ______________________________

Street ______________________________

City ____________________ State______ ZIP ______

❑ Special arrangements ______________________________

SECTION 7 – General Risk Questions

Has the Proposed Insured:

1.	In the past 5 years, done any flying other than as an airline passenger or engaged in vehicle racing, underwater diving, or sky diving?	❑ Yes	❑ No
2.	Any current or expected duties with the Armed Forces?	❑ Yes	❑ No
3.	In the past 3 years, used tobacco products? If Yes, identify what was used, how much, and dates of usage.	❑ Yes	❑ No
4.	In the past 3 years, been convicted of one or more vehicle moving violations, driving under the influence of alcohol or drugs, or ever had a driver's license revoked or suspended?	❑ Yes	❑ No
5.	Ever had an application for life or health insurance declined, postponed, up-rated or modified, or any insurance cancelled or its renewal refused?	❑ Yes	❑ No
6.	Ever claimed disability benefits for an injury, illness, or impaired condition?	❑ Yes	❑ No
7.	Been convicted of a felony?	❑ Yes	❑ No

PART 2

If you need more space, please use the additional information section on page 4.

SECTION 1 – Physician Information

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning the present health of the Proposed Insured.

❑ Check here if no doctor, practitioner, or health care facility is known.

Physician name ____________________ Phone number ( ) ____________________

Name of practice/clinic ____________________ Fax number ( ) ____________________

Street ____________________ City____________ State______ ZIP ________

Date last consulted __________ Provide reasons for treatments and the results. ____________________

____

List all currently prescribed medications, dosage, and frequency. ____________________

____

SECTION 2 – Medical Questions

PLEASE NOTE: If FULL PARAMEDICAL exam is required, completion of medical questions is OPTIONAL but will expedite your application.

1. HEIGHT/WEIGHT Height____________ Weight____________

Has the Proposed Insured experienced a change in weight (greater than 10 pounds) in the past 12 months? ❑ Yes ❑ No

If Yes, specify: Pounds lost_______ Pounds gained_______ Reason ____________________

2. Are the Proposed Insured's parents (P) or any siblings (S) deceased? ❑ Yes ❑ No If Yes, indicate below:

Relationship to Proposed Insured	Age at death	State of health, specific conditions, cause of death
❑ P ❑ S		
❑ P ❑ S		

3. To the best of the Proposed Insured's knowledge and belief, has the Proposed Insured's parents (P) or any siblings (S) ever had heart disease, diabetes, cancer, or mental illness? ❑ Yes ❑ No If Yes, indicate below:

Relationship to Proposed Insured	State of health, specific conditions
❑ P ❑ S	
❑ P ❑ S	

4. Is the Proposed Insured pregnant? ❑ Yes ❑ No Number of past pregnancies____ Any complications with the pregnancies? ❑ Yes ❑ No If Yes, indicate below:

State of health and specific conditions

5. Has the Proposed Insured received counseling or treatment from any physician for, or been convicted for, the use of alcohol or the use and/or possession of drugs? ❑ Yes ❑ No

6. Has the Proposed Insured used amphetamines, barbiturates, cocaine, narcotics, marijuana, or other depressant, excitant, or hallucinatory drugs, unless administered on the advice of a physician? ❑ Yes ❑ No

If you need more space, please use the additional information section below.

SECTION 2 – Medical Questions

7. During the past 10 years, has the Proposed Insured been diagnosed as having, been treated by a member of the medical profession for, or tested positive for:

- **A.** Heart attack; high blood pressure; or stroke? ❑ Yes ❑ No
- **B.** Cancer, tumor, cyst, mass; leukemia; lymph gland; thyroid; chronic fatigue; or any other blood abnormalities? ❑ Yes ❑ No
- **C.** Diabetes or other endocrine disease; sugar, albumin, or blood in urine; stone of kidney, bladder, or prostate? ❑ Yes ❑ No
- **D.** Lung or chronic respiratory disease; asthma; bronchitis; emphysema; pneumonia; or tuberculosis? ❑ Yes ❑ No
- **E.** Intestinal bleeding; ulcer; or hepatitis? ❑ Yes ❑ No
- **F.** Any disease of the reproductive organs or breasts? ❑ Yes ❑ No
- **G.** Brain, mental, or emotional nervous condition; fainting; convulsions; paralysis; depression; anxiety; frequent recurring headaches; any other disease of the nervous system; attempted suicide; or ever been counseled for any of the above? ❑ Yes ❑ No
- **H.** Arthritis; gout, loss of limb, or deformity of the skeletal system, joint, muscle, back, or spine; skin disease? ❑ Yes ❑ No
- **I.** Disease of eye, ears, nose, or throat? ❑ Yes ❑ No
- **J.** Any diagnostic test, such as an electrocardiogram, x-ray, MRI, CT scan, biopsy, or blood study? ❑ Yes ❑ No
- **K.** Any surgery? ❑ Yes ❑ No
- **L.** Advised to have any diagnostic test, hospitalization, or surgery which has not been completed? ❑ Yes ❑ No
- **M.** Treatment as an inpatient or outpatient or is currently confined in a hospital, institution, clinic, sanatorium, or other medical facility? ❑ Yes ❑ No

8. 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 infection? ❑ Yes ❑ No

Details: If you answered YES to any of the above questions, please provide details here.

Question Number	Name of Physician Address if not already provided	Date/Duration of Illness	Diagnosis/Severity Medications/Treatments

Additional Information

Use this page for any additional information. Attach a separate sheet if necessary.

Agreement/Acknowledgement

Agreement/Disclosure

I have read this application for life insurance including any amendments and supplements and, to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any certificate issued.
- This application and any amendment(s), paramedical/medical exam, and supplement(s) to this application will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors of America (Royal Neighbors), become part of the new certificate.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in this application and amendment(s), paramedical/medical exam, and any supplement(s).
- Only authorized officers of Royal Neighbors may: a) make or change any contract of insurance; b) make a binding promise about insurance; or c) change or waive any term of an application, receipt, or certificate.
- Corrections, additions, or changes to this application may be made by Royal Neighbors. Any such changes will be shown under "Corrections and Amendments." Acceptance of a certificate issued with such changes for administrative purposes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, health questions, or benefits unless agreed to in writing by the Applicant.
- Unless otherwise provided by the Conditional Receipt, Royal Neighbors will have no liability under this application unless and until: a) it has been received and approved by Royal Neighbors at its Home Office; b) the certificate has been issued and delivered to the certificateowner; c) the first premium has been paid to and accepted by Royal Neighbors; and d) at the time of delivery and payment, the facts concerning the insurability of the Insured are as stated in this application.
- If not a current member, I hereby apply to become a member of Royal Neighbors as indicated by my signature on page 6. As a member, I agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors of America was founded more than 100 years ago.

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that:
The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:
a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; **OR**
b) the IRS has notified me that I am not subject to backup withholding. *(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*
I am a U.S. citizen or a U.S. resident alien for tax purposes.
Please note: The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Authorization

I, the Proposed Insured, hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), consumer reporting agency, division of motor vehicles, the veterans administration, or other government agency or department having information as to the diagnosis, treatment, or prognosis with respect to any physical or mental condition, or having any non-medical information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past 10 years, without restriction, to Royal Neighbors of America, its agents, employees, representatives, or its reinsurers. This includes information on the treatment of alcohol, drug, and tobacco abuse, and psychiatric diagnosis and treatment. **In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, to give such information to any legal representative or agent employed by Royal Neighbors of America.**

I understand that the protected information is to be disclosed under this authorization so that Royal Neighbors of America may underwrite my application for life insurance, determine my eligibility for insurance, risk rating, or certificate issuance determinations, obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have applied for with Royal Neighbors of America. Any protected information obtained will not be released by Royal Neighbors of America or its reinsurers to any person or organization EXCEPT to other divisions and/or departments of Royal Neighbors of America or its reinsuring companies, MIB, other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted, or other persons or organizations performing business or legal services in connection with my application, insurance certificate(s), or claim for benefits or as may be otherwise lawfully required or as I may further authorize.

(cont'd)

I understand that this authorization shall remain in force for 24 months from the date signed if used in connection with an application for life insurance certificate, an application for reinstatement of a life insurance certificate, or a request for change in certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative is entitled to receive a copy. I understand that this authorization may be revoked by me at any time in writing, and if I refuse to sign or if I subsequently revoke this authorization, Royal Neighbors of America may not be able to process this application, and if coverage has been issued, may not be able to process any benefit payments. I agree that Royal Neighbors of America shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation at its Home Office or to the extent that Royal Neighbors of America has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be re-disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

❑ Check here if a copy of this authorization is desired.

Corrections and Amendments (For Home Office Use Only)

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.

SIGNATURES:

Signed at city, state______________________________ Date______________

☞ **Proposed Insured** ______________________________

Signed at city, state______________________________ Date______________

☞ **Proposed Owner** ______________________________
(If other than Proposed Insured)
(If age 19 or over) If the Owner is a firm or corporation, include Officer's title with signature.

Agent's Report

REPLACEMENT:

Do you have any knowledge or reason to believe that the Proposed Insured has in-force life insurance or annuity contracts that may be replaced as a result of this transaction? ❑ Yes ❑ No

If Yes, have you completed a replacement questionnaire and any other state required replacement forms? ❑ Yes ❑ No

Did you use only written sales material approved for use by Royal Neighbors? ❑ Yes ❑ No

Agent no.______________ Agent license no.______________ Agent chapter no. ______________

☞ Signature of Writing Agent______________________________ Date ______________

Printed name of Writing Agent ______________________________

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Authorization for Pre-Authorized Collection Plan

I authorize Royal Neighbors of America and the financial institution named below to initiate automatic withdrawals from my checking/savings account. This authority will remain in effect until I notify Royal Neighbors of America or the bank to cancel it in such time as to afford a reasonable opportunity to act on the request. I can stop payment of any withdrawal by notifying Royal Neighbors of America three days before my scheduled withdrawal day. Royal Neighbors of America reserves the option to change the method of payment to another qualifying mode after the occurrence of a transaction not honored.

Name of financial institution____________________ City________________ State ______

Name (please print)________________________ Phone number ( )____________

Street address/PO Box ____________________________________

City ________________________ State______ ZIP ____________

I would like the payment withdrawn on the ____4th ____11th ____18th ____26th

Checking account no. ________________ OR Savings account no. ________________

☞ Signature as it appears on bank records (do not print) X ____________________ Date __________

PLEASE RETURN THIS AUTHORIZATION WITH A VOIDED CHECK OR A DEPOSIT SLIP

Important Information for Applicant

Arizona: On written request, Royal Neighbors of America will provide the certificateowner with information regarding the provisions of the life insurance certificate. If for any reason the certificateowner is not satisfied with the life insurance certificate, she/he may return the certificate to Royal Neighbors of America within 20 days (30 days if the certificateowner is 65 years of age or older), after receiving the certificate and receive a refund of all monies paid.

Arkansas, California, New Mexico, Texas, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurer for the purpose of defrauding or attempting to defraud the insurer. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurer or agent of an insurer who knowingly provides false, incomplete, or misleading facts or information to a certificateowner or claimant for the purpose of defrauding or attempting to defraud the certificateowner or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia and Georgia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Indiana and Oklahoma: Any person who knowingly, with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Kentucky and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey: Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

Ohio: Any person who, with intent to defraud, or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Tennessee, Washington, and Maine: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company (insurer) for the purpose of defrauding the insurer. Penalties include imprisonment, fines, and denial of insurance benefits.

Royal Neighbors of America

www.royalneighbors.org

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(800) 627-4762

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Conditional Receipt

Unless each and every condition specified in paragraph 1 below is fulfilled exactly, no insurance will become effective prior to delivery of the certificate of insurance. No agent of Royal Neighbors of America is authorized to alter or waive any of the conditions. Only checks or money orders are acceptable for payment when a conditional receipt is requested.

Received from ______________________________ on (Date)__________ the sum of $__________ in connection with an application to Royal Neighbors of America for the following insurance certificate:

Proposed Insured:______________________________ Life Insurance Amount: $__________ Plan: ______________

1. All of the following conditions must be met before insurance may become effective prior to delivery of the certificate:
   (a) The payment indicated above must be at least equal to one month's premium at the premium class applied for. Assuming all other conditions under this paragraph have been met, if Royal Neighbors of America, in accordance with its rules, would have issued the certificate under a different premium class than applied for, and the premium paid was less than the premium that would have been required for the issuance of a certificate at this new premium class, then the death benefit payable under the receipt shall be such as the premium paid would have purchased at the new premium class.
   (b) All medical examinations and tests required by Royal Neighbors of America must be completed and received at the Home Office of Royal Neighbors of America.
   (c) As of the effective date, as defined below, the Proposed Insured must be a standard risk under rules and practices of Royal Neighbors of America for the plan and the amount of life insurance applied for, without change and at the rate of premium paid.
   (d) As of the effective date, the state of health and all factors affecting the insurance of the Proposed Insured must be as stated in the application.
2. When each and every one of the conditions of paragraph 1 have been met, the insurance coverage, as provided by the terms and conditions of the certificate of life insurance applied for, but for an amount not exceeding $400,000, will begin as of the Effective Date. "Effective Date" as used herein, means the later of:
   (a) the date of completion of the application; or
   (b) the date of completion of all medical examinations, electrocardiograms, x-rays, and other tests required by Royal Neighbors of America.
3. If the conditions have been met and coverage begins, coverage under this receipt will terminate 60 days from the date of this receipt unless prior to that date the insurance certificate is issued and accepted.

☞ Signature of Agent Receiving the Payment______________________________

I understand and agree to the terms, conditions, and limits of this receipt and the agreements in the application, all of which have been fully explained to me by the agent.

☞ Signature of Proposed Owner ______________________________ Date ______________

NOTE: This receipt is to be issued only if the required payment is submitted with the application.

Medical Information Bureau, Inc. (MIB), Notice

This Notice is to be detached, read, and retained by the Proposed Insured

Information regarding your insurability will be treated as confidential. Royal Neighbors of America or its reinsurers make a brief report thereon to the Medical Information Bureau, Inc., a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or if a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901, TTY (866) 346-3642. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Report Act. The address of MIB's information office is: MIB, P.O. Box 105, Essex Station, Boston, MA 02112.

Royal Neighbors of America or its reinsurers may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

Fair Credit Report Act Notice

This is to inform you that as part of our underwriting procedures in connection with this application, an investigative consumer report may be obtained on the Proposed Insured and the Proposed Owner. This report will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with neighbors, friends, and associates. You may request to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. No information collected concerning the sexual orientation of the Proposed Insured or Proposed Owner will be used to determine her or his eligibility for life insurance.