LIFE

THE PROVIDENCE ASSOCIATION OF UKRAINIAN CATHOLICS IN AMERICA

APPLICATION

A Fraternal Benefit Society
817 - 19 North Franklin Street
Philadelphia, PA 19123-2004
Phone: 1-215-627-4984 FAX: 1-215-238-1933

I hereby make application to the Providence Association for a certificate of Life Insurance to be issued upon the basis of my answers to the following questions:

Please print all answers.

Social Security # _____

Are you insured with the PAUC? ❑ Yes; ❑ No. If no, apply for membership.

Date of Birth _____ Age _____ Sex _____

Birthplace _____

1. Proposed Insured _____
2. Address _____
   City _____ State _____ Zip _____
3. Phone # (Day) ( )_____ (evening) ( )_____
4. Height _____ Weight _____
5. Occupation _____
6. Beneficiary _____
   Relationship to insured _____ Birth date _____
   Address _____
   Contingent Beneficiary _____
   Relationship to Insured _____ Birth date _____
   Address _____
   ❑ Irrevocable Beneficiary (for charitable giving)
7. Certificate Owner: ❑ Proposed Insured (must be 16 or older):
   ❑ If other than Proposed Insured, complete below:
   Full Name _____
   Address _____
   Relationship to Proposed Insured _____

Type of Insurance:

Amount of Insurance Applied for:

$_____

Riders:

Payor Member ❑ Yes ❑ No

Double Indemnity ❑ Yes ❑ No

Other Riders_____

Total Premium	Annual	Semi-Ann.	Quarterly
Premium			
Payor Member			
Double Indemnity			
Newspaper			
Fraternal Funds			
Other Riders			
TOTAL			

Amount Paid with Application:

$_____ Mode: _____

I request that the certificate, if issued, be effective with the month of:

_____, _____

If you answer yes to any of the following questions, 8 thru 12, please explain on the other side.

8. Will this certificate replace or change any other insurance or annuity in the PAUC or any other company? ❑ Yes ❑ No
9. Have you made application for other life or health insurance without receiving policy as applied for? ❑ Yes ❑ No
10. Has the proposed insured ever made application for a disability pension? ❑ Yes ❑ No
11. Has a health care provider treated or diagnosed the proposed insured, in the past ten years, for any disease or disorder of:
    (a) Nervous system; epilepsy; or paralysis? Arthritis or any disease of the joints; back; or spine? ❑ Yes ❑ No
    (b) The heart or blood vessels; chest pains; high or low blood pressure; rheumatic fever? ❑ Yes ❑ No
    (c) Stomach; liver; intestines; gall bladder? ❑ Yes ❑ No
    (d) The kidney; urinary; bladder; prostate? ❑ Yes ❑ No
    (e) Lungs; asthma; tuberculosis? ❑ Yes ❑ No

12. Within the past five years have you: been a patient in a hospital, clinic, sanitarium, or other medical facilities; seen a doctor for treatment or consultation for any reason; have been advised to have any diagnostic test, hospitalization, or surgery which was not completed. ❑ Yes ❑ No
    (a) Do you now use tobacco? ❑ Yes ❑ No
    (b) Ever used tobacco? ❑ Yes ❑ No
    (c) In the past ten years, have you been treated for alcoholism or any drug habit? ❑ Yes ❑ No

The state of your health is, of course, extremely important to us. When you apply for a certificate, we may ask you additional questions about your medical history and we may even ask you to take a physical examination at our expense.

13. If the Association declares a dividend, I would like it applied as:
    1. ❑ Cash; 2. ❑ Reduced Premium; 3. ❑ Additional paid up insurance; 4. ❑ Accumulate

Pre-Notice

Information regarding your insurability will be treated as confidential. The Providence Association, or its reinsurer(s) may, however, make a report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates as information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company the Bureau, upon request, will supply such company with the information in its file. The Providence Association or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number: 1-617-426-3660.

I further understand that in connection with this application for insurance, an investigative consumer report may be made as to my insurability, whereby information may be obtained through interviews with neighbors; friends; and associates; and which may include, if applicable, information to character; general reputation; personal characteristics; and mode of living. The consumer may inquire whether or not an investigative consumer report was requested, and if so, shall be given the name and address of the investigative consumer reporting agency to obtain a copy of the report.

Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Providence Association or its reinsurer(s), or its authorized representatives, including Equifax, or bearer, any such information. The Providence Association may disclose such information to its reinsurer(s) or the Medical Information Bureau. The authorization is valid for 30 months after the date shown below.

A photographic copy of this authorization shall be as valid as the original.

Fraud Warning Notice

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.

CONDITIONAL RECEIPT RECEIVED BY APPLICANT **❑ Yes ❑ No**

I (WE) HEREBY DECLARE that all statements and answers herein are full, complete and true, to the best of my (our) knowledge and belief.

Dated at _____ this _____ day of _____, _____

Applicant Signature _____

Signature of other, if Proposed Insurer is a minor. _____

Recruiter _____ Proposed Insured Branch Preference _____

THE PROVIDENCE ASSOCIATION • 817 North Franklin Street • Philadelphia, PA 19123-2004

Space Available for Explanation of Number 8 thru 12.

Treated for	Duration of Illness	Doctor's Full Name and Address	Dates Attended

For Home Office Use:

Approved by Home Office: _____ **Medical Director** _____