POLISH FALCONS OF AMERICA
THE STRONG, FRIENDLY, FAMILY FRATERNAL

POLISH FALCONS OF AMERICA
1016 GREENTREE ROAD, SUITE 201
PITTSBURGH, PENNSYLVANIA 15220-3125
A Fraternal Benefit Society

Application for Individual Final Expense Life Insurance

Is the Applicant an existing member of Polish Falcons of America? Yes No
If No, apply for membership.

Each of the undersigned declares that the Proposed Insured(s) is/are eligible for membership under the rules set forth in the Articles of Incorporation and Bylaws of Polish Falcons of America.

Proposed Insured's Name: _____

Signature_____ Date_____

1. Proposed Insured First Name, Middle Initial, Last Name	2. Social Security Number	3. Birthdate Mo. Day Year	4. Age
		/ /	

5. Sex Male Female	6. Maiden Name (if applicable)	7. Place of Birth

8. Marital Status Single Married Divorced Widowed

9. Phone: Home_____
Work_____
Cell_____
Best time to call:_____ AM/PM

10. Relationship of insured to applicant:

11. Proposed Insured's occupation/duties: _____

12. Is Proposed Insured's occupational status restricted due to any health condition? Yes No

13. Street Address: _____

City: _____ State: _____ Zip: _____ How Long Here? _____

Mailing Address (if different): _____

14. Email Address: _____

15. Do you have existing life insurance policies or annuity contracts in force with this or any other company? Yes No

16. Is the insurance applied for intended to replace or change any insurance policy or annuity now in force with this or any other company ? Yes No

If yes, furnish insurance company's name and address and the policy number to be replaced.

_____

Ultimate Face Amount $ _____

Premium Amount: $ _____ **Amount Remitted with Application:** $ _____

Premium Mode:

Annual	bank draft	direct
Semi-Annual	bank draft	direct
Quarterly	bank draft	direct
Monthly (bank draft only)		
Single Premium		

Declaration of Insurability

Part A – TO BE COMPLETED BY ALL APPLICANTS

1. Is the Proposed Insured currently taking any medications? ..... Yes No

   If "yes," please list: _____

2. Current Height _____ Current Weight _____

3. Has the Proposed Insured used any form of tobacco or nicotine replacement products in the past 12 months?..... Yes No

Part B – IF ANY QUESTIONS IN PART B ARE ANSWERED "YES," COVERAGE WILL NOT BE ISSUED.

4. Has the Proposed Insured been diagnosed by a member of the medical profession as having a life expectancy of 12 months or less?..... Yes No

5. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ..... Yes No

6. In the past 5 years, has the Proposed Insured received an organ transplant or been advised by a member of the medical profession to receive an organ or tissue transplant? ..... Yes No

7. Is the Proposed Insured currently hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care or confined to a wheelchair?..... Yes No

8. Has the Proposed Insured ever been diagnosed as having or been treated for, by a member of the medical profession, Alzheimer's Disease or dementia? ..... ☐ Yes ☐ No

Part C – IF ANY QUESTIONS IN PART C ARE ANSWERED "YES," A GRADED BENEFIT POLICY MAY BE ISSUED.

9. In the past 5 years, has the Proposed Insured been diagnosed as having or been treated for, by a member of the medical profession, internal cancer, malignant melanoma or leukemia? ..... Yes No

10. In the past 18 months, has the Proposed Insured had heart surgery, been diagnosed as having or been treated For, by a member of the medical profession, heart attack, stroke, aneurysm, angina (chest pain), congestive heart failure, cardiomyopathy, kidney dialysis, or used oxygen to assist in breathing? ..... Yes No

11. In the past 18 months, has the Proposed Insured had a drug or alcohol dependency/habit or had treatment for alcoholism or drug addiction? ..... Yes No

12. In the past 18 months, has the Proposed Insured had amputation due to disease?..... Yes No

13. In the past 5 years, has the Proposed Insured been diagnosed as having or been treated for, or been prescribed medication for, by a member of the medical profession, any of the following conditions (if "yes", check the applicable condition)? ..... Yes No

    ☐ emphysema ☐ chronic lung disease (COPD) ☐ Parkinson's Disease ☐ kidney disease

    ☐ kidney failure ☐ cirrhosis ☐ other liver disease ☐ sickle cell anemia

14. In the past 2 years, has the Proposed Insured been diagnosed as having or been treated for, or been prescribed medication for, by a member of the medical profession, any of the following conditions (if "yes", check the applicable condition)?..... Yes No

    ☐ brain tumor ☐ pacemaker ☐ angina (chest pain) ☐ heart attack ☐ congestive heart failure

    ☐ stroke ☐ aneurysm ☐ any other heart disorder ☐ circulatory disorder ☐ uncontrolled high blood pressure

    ☐ insulin dependent diabetes ☐ pulmonary or chronic respiratory disorder

Selection of Coverage

Non-tobacco Tobacco

Base Plan of Insurance	Ultimate Face Amount	Riders (available only on level benefit plan)	Amount of Rider (Face Amount)
☐ Level Benefit–Lifetime Pay	$	☐ Accidental Death	$
☐ Level Benefit–Single Pay	$	☐ Accidental Death	$
☐ Graded Benefit	$		

DESCRIPTION OF DEATH BENEFITS OTHER THAN ACCIDENTAL DEATH*

Level – 100% of Ultimate Face Amount

Graded * – Certificate Year 1 – 30% of Ultimate Face Amount
Certificate Year 2 – 70% of Ultimate Face Amount
Certificate Years 3 and later—100% of Ultimate Face Amount

***** *For accidental death, the Ultimate Face Amount is paid in years 1-2 for Graded plan*

Beneficiary Designation

(If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name Relationship to You Share

Beneficiary Address City State Zip

Contingent Beneficiary Name Relationship to You Share

Contingent Beneficiary Address City State Zip

Owner Designation

Owner of the policy is: ☐ Applicant ☐ Proposed Insured Other

Name of Owner (if other than Proposed Insured): _____

Owner's address: _____

Relationship of Owner to Proposed Insured: _____

Authorization

Polish Falcons of America may release information to the MIB pursuant to this notice. I have read the questions and answers written in this application, and to the best of my knowledge and belief, they are true and complete. I authorize the release of medical or non- medical information to Polish Falcons of America from: any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, MIB, Inc., or other organization, institution, or person which has any records or knowledge of me, or my health, to Polish Falcons of America or its reinsurers. I hereby authorize Polish Falcons of America to use one of its approved vendors to check my usage of prescription medication. I understand that a telephone interview may be conducted to verify application.

This Authorization will be valid for either (1) 24 months; or (2) the maximum period of time permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand that this Authorization may be revoked at any time by requesting such of the providing organization in writing at the address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original. I, or my authorized representative, may also request a copy of this Authorization.

It is agreed that the insurance applied for shall be subject to the conditions and provisions of the contract of insurance and shall not be in force until the application is accepted and the contract of insurance issued by Polish Falcons of America.

POLISH FALCONS OF AMERICA IS LICENSED TO DO BUSINESS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN ANY STATE'S LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOWN AS THE GUARANTY ASSOCIATION). THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY.

FRAUD WARNING NOTICE

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed: _____ at _____

(Month, Day, Year) (City) (State)

Witnessed by _____ _____

Polish Falcons of America Licensed Representative Signature of Proposed Insured

_____ _____

Representative Writing Number Signature of Applicant/Owner
(Only if other than Proposed Insured)

Representative's Statement

1.	Did you complete a Financial Needs Analysis in connection with this application?	Yes	No
2.	Did Proposed Insured or Proposed Insured's family contact you for this coverage?	Yes	No
3.	Is the insurance applied for intended to replace any other insurance in force?	Yes	No
4.	Did you personally see the Proposed Insured and ask each question? (Explain why not below)	Yes	No

Additional Information and details:

To the best of my knowledge and belief:

1. I have asked all questions and recorded all answers as they were given to me by the Proposed Insured.
2. I know nothing about the Proposed Insured's health, habits, avocations, or life-style affecting insurability which has not been stated in this application.
3. Buyer's Guide(s) was left with the Proposed Insured.

Signature of Polish Falcons of America Licensed Representative

Date

NEST USE ONLY
NEST No. _____

We recommend the Applicant be admitted to membership in the Polish Falcons of America, and that the certificate applied for be issued.

Nest President

Nest Financial Secretary

NOTICE TO PROPOSED INSURED

I understand that information regarding my insurability will be treated as confidential. The Polish Falcons of America may, however, make a brief report thereon to the MIB, Inc. formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange in behalf of its members. Should I 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 it may have in its files.

Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my file. (Medical information will be disclosed only to my attending physician.) I may contact MIB at 866-692-6901 (TTY 866-346-3642). Should I have a question regarding the accuracy of information in MIB's file, I may contact MIB 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: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Polish Falcons of America may also release information in its file to other life insurance companies to whom I may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.org.

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 about character, general reputation, personal characteristics and mode of living. Additional detailed information as to the nature and scope of any investigation will be furnished upon written request.