First Catholic Slovak Ladies Association

A Fraternal Benefit Society
24950 Chagrin Boulevard, Beachwood Ohio 44122
800.464.4642

Application for Life Insurance

First **Catholic** Slovak Ladies **Association**
Of the United States of America

A Fraternal Benefit Society
24950 Chagrin Boulevard, Beachwood, OH 44122 1-800-464-4642

LIFE INSURANCE APPLICATION

Please Print - Use Black Ink Only.

Branch #: _____ Location: _____ Certificate #: _____

1. Proposed Insured

First Middle Last Suffix

Name: _____ Height:_____ Weight:_____

Address: _____ Telephone #: (_____)_____

_____ Date of Birth:_____/_____/_____ Sex: ____

Maiden Name if Female: _____ Place of Birth: _____U.S. Citizen: Y / N.

Driver's License Number: _____ Social Security Number: _____-____-_____

Employer: _____ Occupation: _____

Is the Proposed Insured a member of First Catholic Slovak Ladies Association? ___Yes ___No. (If not, apply for membership.)

2. Plan of Insurance, Benefits, and Riders

Plan Name/Type:_____ Face Amount: _____

Additional Benefits/Riders: _____ Amount Paid with Application: $_____

Mode: ____ Annual ____Semi-Annual ____Quarterly ____Monthly ____Single. Modal Premium: $_____

Electronic Fund Transfer (if applicable) _____Yes _____No.

Certificate to be Dated: _____/_____/_____ Automatic Premium Loan? ____Yes ____No.

Dividend option, if participating: (check one)

____Purchase Paid-Up Additional Life Insurance (Recommended) ____Accumulate ____Cash ____Reduce Premium.

3. Owner Information *(If other than Proposed Insured)*

Owner Name:_____ Social Security Number: _____

Address: _____ Relationship to Insured: _____

_____ Telephone #: ( ) _____

4. Beneficiary Designation *(If more space is needed use an additional sheet. Date, sign, and attach to this application.)*

	Name	Relationship to Proposed Insured	Date of Birth	Social Security #	Share (%)
Primary:					
	Name	Relationship to Proposed Insured	Date of Birth	Social Security #	Share (%)
Contingent:					

5. Existing Life Insurance and Annuity Information

a. Other Life Insurance or annuities in force? _____ Yes _____ No.

If Yes, total amount of life insurance: $_____ Total amount of annuities: $_____

b. Are other applications pending with any insurer? ____ Yes ____ No.

c. Will this application change or replace any existing life insurance or annuity? ____Yes ____No.

d. Will any existing values from another policy or annuity (through loans, surrenders, or otherwise), be used to pay premiums for the policy applied for? ___Yes ____No.

If Yes to a, b, c, or d, list the insurer and the policy number. _____

The First Catholic Slovak Ladies Association of the USA
Beachwood, OH 44122

6. Underwriting Information

Is the Proposed Insured now receiving, or in the past 10 years, has the Proposed Insured received medical or surgical care or treatment, been diagnosed with, or advised to seek treatment for:	**Yes**	**No**
a) Lung disease, asthma, pleurisy, recurrent pneumonia, emphysema, chronic cough, or tuberculosis?	____	____
b) Sugar, albumin, blood or pus in the urine, kidney stone, any disease or disorder of the kidney, bladder, prostate, reproductive or genito-urinary system?	____	____
c) Diabetes, goiter; cancer or tumor; skin lesion, Kaposi's Sarcoma, abnormal growth of any kind, disorder of the lymph glands or endocrine disorder?	____	____
d) Heart disease, chest pain, rheumatic fever, high or low blood pressure, anemia, any disease or disorder of the heart, blood, or circulatory system, shortness of breath, heart enlargement, abnormal heart rhythm or palpitations, atrial fibrillation?	____	____
e) Disorder of the brain or nervous system, mental disorder, emotional disorder, dizziness, loss of consciousness, convulsions, epilepsy, stroke, dementia, Alzheimer's, autism, Down's Syndrome, Stroke, TIA (Transient Ischemic Attack/mini stroke)?	____	____
f) Stomach or duodenal ulcer, hernia, chronic indigestion, GERD, any disease or disorder of the esophagus, stomach, intestines, rectum, liver, or gall bladder?	____	____
g) Eye or ear disease or disorder?	____	____
h) Gout, rheumatism, arthritis, spine or back disease or disorder, multiple sclerosis, disorder of the muscles or bones?	____	____
i) Sexually transmitted disease or disorder including but not limited to syphilis, gonorrhea, hepatitis B or genital herpes?	____	____
j) Alcoholism or the excessive use of alcohol, or the use of any controlled substance?	____	____
k) Any disease or disorder not listed above? (See 7a for AIDS/ARC/HIV.)	____	____

7. Additional Underwriting questions

a) In the past 10 years, has the Proposed Insured ever been treated or diagnosed by a physician for: Acquired Immune Deficiency Syndrome (AIDS); Aids Related Complex (ARC); or positive Human Immunodeficiency Virus (HIV) test?	____	____
b) In the past 5 years has the Proposed Insured: been charged with a driving while impaired (alcohol, drugs, other) violation; had a drivers license revoked, suspended or restricted; or within the last 36 months received 3 or more citations for moving violations?	____	____
c) Has the Proposed Insured been arrested or convicted for any criminal offense; or is currently on parole or probation?	____	____
d) In the past 2 years, has the Proposed Insured engaged in: racing, scuba diving, hang gliding, sky diving, mountain or rock climbing; or other hazardous sport or avocation?	____	____
e) Has the Proposed Insured used tobacco in any form during the past 12 months?	____	____
f) In the past 2 years, has the Proposed Insured flown as a pilot, crew member, or had any duties aboard an aircraft? Is there any intention of doing so?	____	____
g) Has the Proposed Insured ever: had an application for life insurance declined, postponed, modified; or been charged an increased premium?	____	____
h) Does the Proposed Insured have plans to travel or reside outside the United States within the next 12 months?	____	____
i) Other than stated above, within the last 5 years has the Proposed Insured: consulted, received treatment or advice from, or been prescribed medication by any member of the medical profession; or had any diagnostic test, excluding AIDS, ARC and HIV?	____	____
j) Has the Proposed Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer, stroke or other hereditary disease? If yes, indicate family member, illness, age at onset, and if applicable, age at death.	____	____

For "**Yes"** answers to Question 6 or 7, please provide details including dates, physician, or hospital information.

List all current medications:

Height: _____ Weight:_____ Amount of weight gained or lost in the last 12 months: _____
Reason:_____

If the insurance coverage sought exceeds $25,000 **- OR -** if you have answered "Yes" to Questions 6 or 7, please provide the following:

Primary Care Physician Name.	Specialist Name.
Address.	Address.
City. State. Zip.	City. State. Zip.
Telephone Number.	Telephone Number.
Date and reason for last consultation and results, treatment and/or medication recommended:	Date and reason for last consultation and results, treatment and/or medication recommended:

FRAUD WARNINGS

For your protection, various state laws require the following statements to appear on this form.

For Residents of Alaska, Arizona, Kansas, Kentucky, Nebraska, Pennsylvania, West Virginia and other states not listed below: 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 the person to criminal and civil penalties.

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

For Residents of Arkansas, Louisiana, Maryland and New Mexico: Any person who knowingly and willfully 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.

For Residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

For Residents of Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly and with intent to defraud or deceive an insurer files a false statement of claim containing any false, incomplete or misleading information commits a felony.

For Residents of District of Columbia, Maine, Tennessee, Texas, Virginia, and Washington: It is a crime to **knowingly** provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For Residents of Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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

Having read the preceding statements and answers, I represent that they are true and complete to the best of my knowledge and belief. I understand that this application shall be the basis for and a part of any contract issued; and no agent or person other than an executive officer of the Association may; change or modify any of the printed statements included herein; or waive any of the Association's rights or requirements.

Except as may be provided in a Conditional Receipt bearing the same date as this application, no insurance shall take effect unless and until: this application is approved at our Home Office, a contract is issued, delivered to and accepted by its owner; and the first full premium for the contract is paid. All such must occur while the health and other factors affecting the insurability of the Proposed Insured remain as described in this application.

Signed at: City, State. *Date.*

Proposed Owner's Signature *(If other than Proposed Insured).*

Proposed Insured's Signature.
(Parent or Guardian if Proposed Insured is under age 16.)
(In **North Carolina**, Parent or Guardian of Proposed Insured under age 15.)

Agent/Witness Signature . ***Agent ID#.***

Agent/Witness Printed Name.

The First Catholic Slovak Ladies Association of the USA
Beachwood, OH 44122

Agent/Fieldworker/Recommender's Report

1. Purpose of Insurance Applied for:
☐ Final Expenses ☐ Family Income ☐ Mortgage Coverage ☐ Charitable Giving
☐ Retirement Planning ☐ Estate Planning ☐ Other_____.

2. Have you ordered any of the following medical requirements:
☐ Paramed Exam ☐ Saliva ☐ EKG ☐ M.D. Exam ☐ APS ☐ Blood Profile

3. Does the Proposed Insured have applications pending with any other insurer? _____ Yes _____ No.
(If yes, please provide insurer and amount.)_____

4. To the best of my knowledge and belief:
A. I have asked the Proposed Insured each question on the application. The answers have been recorded by me exactly as stated.
B. I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application.
C. I have accurately answered any questions contained in the Agent's Report completed by me in connection with this application.
D. I have verified the Proposed Insured's identity by viewing the individual's photograph on a driver's license, passport, or other official document.
E. I have reviewed the entire application for corrections or omissions.
F. I have personally solicited and secured this application.

Comments:

Agent/Fieldworker/Recommender's Interrogatory

1. To the Best of your knowledge and belief, does the Proposed Insured have existing life insurance or annuity policies in force? _____ Yes _____ No
(If yes, please provide insurer and amount.)_____

2. To the best of your knowledge and belief, will the insurance now applied for replace or change any existing insurance or annuity? _____ Yes _____ No

Agent: If the answer to Question #1 and/or Question #2 is Yes, you must present and read to the Applicant the Important Notice Regarding Replacement of Life Insurance or Annuities and return the Notice, signed by both you and the Applicant, with the completed application.

3. Advertising Materials:
I certify that I used FCSLA approved sales materials with this Applicant in the solicitation of this application.

I certify that this application is in accordance with FCSLA's Position Regarding the Replacement of Life Insurance and Annuity Policies.

By signing as Fieldworker/Recommender/Agent, I affirm that I am in compliance with the insurance sales laws of the state in which the certificate was sold.

Printed Name of Fieldworker/Recommender/Agent.	Agent ID#.	Date.
Signature of Fieldworker/Recommender/Agent.	Agent ID#.	Telephone Number.
Address.		E-mail Address.
Address.		Fax Number.

The First Catholic Slovak Ladies Association of the USA
Beachwood, OH 44122

Medical Information Bureau (MIB) Notice to Proposed Insured

Information regarding your insurability will be treated as confidential. First Catholic Slovak Ladies Association of the USA or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information in your file. Please contact MIB at [866-692-6901 (TTY 866-346-3642)]. If you question the accuracy of the 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 Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

The First Catholic Slovak Ladies Association of the USA, or its reinsurers, may also release information from its file to other insurance companies to whom you 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.com].

AUTHORIZATION

I AUTHORIZE any of the following that have any records or information regarding the proposed Insured, including driving records or controlled substance or alcohol abuse, to provide such records or information to The First Catholic Slovak Ladies Association of the USA, its legal representative(s), or its reinsurer(s): (1) any licensed physician or medical practitioner; (2) any hospital or clinic, medical or medically related facility; or (3) the Medical Information Bureau, pharmacy benefits manager, any consumer reporting agency or other such organization, insurer or reinsurer, employer, institution, government agency or person.

I UNDERSTAND THAT: (1) on request, I, or a person acting on my behalf, may receive a copy of this authorization; and (2) the information obtained by use of this authorization will be used (a) to determine the eligibility of the Proposed Insured for insurance, or (b) to determine eligibility for benefits in the event of a claim.

I AGREE that this authorization, or a copy, shall be valid for a period of 24 months from the date shown below.

Printed Name of Proposed Insured.	*Date.*
Signature of Proposed Insured (Parent or Guardian if under age 16). *(In **North Carolina**, Parent or Guardian of Proposed Insured under Age 15.)*	*Witness.*

Additional Remarks:

First **Catholic** Slovak Ladies **Association**

24950 Chagrin Blvd, Beachwood, OH 44122-5634 800-464-4642

HIPAA Authorization

This Authorization permits your physician, doctor, or health care provider to disclose protected health information ("PHI") to First Catholic Slovak Ladies Association of the United States of America ("FCSLA") for processing your life insurance application.

I. Information About the Use or Disclosure of Individually Identifiable Health Information

I, _____ (Print Name) hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that individually identifiable health information: (A) either identifies or reasonably may be used to identify the individual who is the subject of the information; and (B) includes information regarding his or her physical or mental condition and/or payment for health care**.** I have read this Authorization in its entirety, including the Section labeled "Important Information About My Rights," and hereby authorize and consent to the use or disclosure of my individually identifiable health information as described below.

_____(Name of Disclosing Party) is authorized to disclose the information described below.

Specific and meaningful description of information to be used or disclosed:

_____

I authorize disclosure of the information to FCSLA for the purpose of processing my life insurance application. A photocopy of this document is valid as an original.

This Authorization will expire one year after the date of execution below.

II. Important Information About My Rights

- This Authorization is voluntary and I may revoke this Authorization at any time by submitting a written revocation to _____(Name and Address of Disclosing Party). The revocation will not have any effect on any actions taken before receipt of the revocation, as may be described in the health plan's notice of privacy practices.
- I may request to see and copy the information described in this Authorization.
- I am entitled to a signed copy of this Authorization.
- Treatment will not be conditioned upon my signing this Authorization and the execution of this Authorization is completely voluntary.
- The information that is used or disclosed pursuant to this Authorization may be redisclosed by FCSLA. Upon disclosure to FCSLA, the information will no longer be subject to the privacy regulations under the Health Insurance Portability and Accountability Act or State law.

III. Signature of Participant or Participant's Personal Representative

_____ _____

Signature of patient/applicant **Date**

Printed name of the patient/applicant's personal representative (if applicable):_____

Relationship to the patient/applicant, including authority for status as representative (if applicable):

First **Catholic** Slovak
Ladies **Association**
Of the United States of America

24950 Chagrin Boulevard, Beachwood, OH 44122 1-800-464-4642

A Fraternal Benefit Society - Since 1892

MEMBERSHIP ELIGIBILITY

Full Name: _____

Are you currently a member of FCSLA? _____Yes _____No

Are you Slovak? _____ Other Slav lineage? _____

Are you Catholic? _____Yes _____No

Is your spouse or other relative, a member? _____Yes _____No

I Hereby apply for membership in the First Catholic Slovak Ladies Association and declare that the above answers are correct to the best of my knowledge and belief and have read the Notice to Applicants regarding the Constitution and Bylaws of the First Catholic Slovak Ladies Association of the United States of America as stated below.

_____ _____

Signature of Proposed Insured *(Parent or Guardian if under age 16)* *Date*

CERTIFICATE OF BRANCH OFFICERS

The herein name applicant is acceptable for membership in:

Branch_____, City, State _____

_____ _____

Branch Officer *Date*

Notice to Applicants regarding the Constitution and Bylaws of the First Catholic Slovak Ladies Association of the United States of America

The applicant understands that the Constitution and Bylaws of the First Catholic Slovak Ladies Association of the United States of America ("FCSLA") requires that all candidates for officer/board position must be of Slovak ancestry. If applicant becomes a member, he/she shall abide by the Constitution and Bylaws and support the vision and mission statement of FCSLA as set forth below.

Vision:

- Promote the temporal and spiritual welfare of members through fraternal and charitable activites in our community.
- Promote our Catholic values, Slovak traditions and all Slavic cultures.
- Be a premier Fraternal Benefit Society that offers quality financial products and benefits.

Mission Statement:

Established in 1892, the FCSLA provides financial security to its members nationwide through its premier life insurance and annuity products. Sales of these products allow FCSLA to serve both its members and the community with fraternal and charitable opportunities that promote Catholic and Slavic traditions.

First **Catholic** Slovak Ladies **Association**

MIB Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, **MIB, Inc.("MIB")** or other organization, institution or person, that has any records or knowledge of me or my health, to give to the First Catholic Slovak Ladies Association of the USA, or its reinsurers, any such information.

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

_____ _____

Signature of Proposed Insured (Parent or Guardian if Proposed Insured is under age 16) *Date*

By signing below, I agree that I have received a copy of the MIB Notice to the Proposed Insured.

_____ _____

Signature of Proposed Insured (Parent or Guardian if Proposed Insured is under age 16) *Date*

(Please detach. This section to be retained by Proposed Insured.)

MIB Notice to the Proposed Insured

Information regarding your insurability will be treated as confidential. The First Catholic Slovak Ladies Association of the USA or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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 Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

First Catholic Slovak Ladies Association of the USA, or its reinsurers, may also release information from its file to other insurance companies to whom you 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.com.

First **Catholic** Slovak Ladies **Association**

IMPORTANT NOTICE:

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance certificate or annuity certificate. In some cases, this purchase may involve discontinuing or changing an existing certificate or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A **replacement** occurs when a new certificate is purchased, and in connection with the sale, you discontinue making premium payments on the existing certificate, or an existing certificate is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A **financed purchase** occurs when the purchase of a new life insurance certificate involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing certificate to pay all or part of any premium or payment due on the new certificate. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your certificate. You may be able to make changes to your existing certificate to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing certificate and may reduce the amount paid upon the death of the Insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing certificate? …… ☐ Yes ☐ No

2. Are you considering using funds from your existing certificate to pay premium due on the new certificate…… ☐ Yes ☐ No

If you answered "yes" to either of the above questions, list each existing certificate you are contemplating replacing (include the name of the insurer, the insured, and the certificate number if available) and whether each certificate will be replace or used as a source of financing:

INSURER NAME	CERTIFICATE #	INSURED	REPLACED (R) OR FINANCING (F)
1.			(____)
2.			(____)
3.			(____)

Make sure you know the facts. Contact your existing company or its agent for information about the old certificate. [If you request one, an in-force illustration, certificate summary, or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing certificate is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate.
The signature of the agent is also an affirmation that the agent has left copies of all sales material with the applicant.

_____	_____	_____
SIGNATURE OF INSURED (AGE 16 & ABOVE)	PRINTED NAME	DATE
_____	_____	_____
SIGNATURE OF OWNER/APPLICANT (IF NOT INSURED)	PRINTED NAME	DATE
_____	_____	_____
SIGNATURE OF AGENT	PRINTED NAME	DATE

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

continued

Main Office: 24950 Chagrin Blvd • Beachwood, OH 44122 • www.fcsla.com
Phone: (216) 464-8015 • Fax: (216) 464-9260 • Toll Free: 1-800-464-4642 • E-Mail: info@fcsla.com

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing certificate and the proposed certificate. One way to do this is to ask the company or agent that sold you your existing certificate to provide you with information concerning your existing certificate. This may include an illustration of how your existing certificate is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare certificates. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?

Could they change?

You're older – are premiums higher for the proposed new certificate?

How long will you have to pay premiums on the new certificate? On the old certificate?

POLICY VALUES:

New certificates usually take longer to build cash values and to pay dividends.

Acquisition costs for the old certificate may have been paid; you will incur costs for the new one.

What surrender charges do the certificates have?

Does the new certificate provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old certificate, the new one could cost more, or you could be turned down.

You may need a medical exam for a new certificate.

Claims on most new certificates for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD CERTIFICATE AS WELL AS THE NEW CERTIFICATE:

How are premiums for both certificates being paid?

How will the premiums on your existing certificate be affected?

Will a loan be deducted from death benefits?

What values from the old certificate are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old certificate?

What are the interest rate guarantees for the new certificate?

Have you compared the contract charges or other certificate expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new certificate?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old certificate under the federal tax code?

Will the existing insurer be willing to modify the old certificate?

How does the quality and financial stability of the new company compare with your existing company?

You have the right to return the contract within thirty (30) days of delivery of the contract and receive an unconditional full refund on all premiums or considerations paid on it, including any policy fees or charges.

First Catholic Slovak Ladies Association
24950 Chagrin Boulevard, Beachwood, OH 44122-5634 (216) 464-8015

CONDITIONAL RECEIPT

NOTICE TO PROPOSED INSURED AND OWNER. No agent or representative has the authority to alter the terms or conditions of this receipt. This receipt shall be void if altered or modified. Please notify First Catholic Slovak Ladies Association if, within 60 days following the date of this receipt, you have not received: 1) the certificate applied for; or (2) refund of your payment. Please be certain to include (1) the amount paid; (2) the date of the payment; and (3) the name of the agent or representative to whom payment was given. **EVERY REMITTANCE MUST BE PAYABLE TO: FIRST CATHOLIC SLOVAK LADIES ASSOCIATION (FCSLA). DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. DO NOT PAY CASH.**

No payment may be accepted with the application *if, within the last 10 years, the Proposed Insured has been treated for or diagnosed by a member of the medical profession as having: AIDS or any other immunological disorder; any cardiovascular or pulmonary condition, stroke, cancer, alcoholism, drug dependence or insulin dependent diabetes.*

CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE PRIOR TO DELIVERY OF THE CERTIFICATE:

1. An amount equal to the modal premium indicated on the application must be submitted; and
2. All medical examinations, tests, x-rays, electrocardiograms, or medical records initially required by FCSLA's published underwriting rules with regard to age and amount applied for must be completed within 45 days from the date of this receipt; and
3. The Proposed Insured is insurable as a standard risk for the insurance applied for as of the effective date; and
4. The state of health and all factors affecting the insurability of the Proposed Insured must be as stated in the application required by FCSLA; and
5. Any check or money order given in payment is honored when first presented.

MAXIMUM AMOUNT. The maximum amount of insurance for which FCSLA shall be liable under this Conditional Receipt shall be the lesser of: (a) the amount of insurance applied for or (b) $100,000.00. Such maximum amount shall include for each Proposed Insured: (a) the amount of insurance requested by the application; and (b) any other insurance currently applied for and pending with the First Catholic Slovak Ladies Association under another application or applications.

MAXIMUM AGE. There is no conditional coverage after insurance age seventy (70).

EFFECTIVE DATE. If all the conditions above are met, then the certificate will have the date of the application as its Effective Date, unless the Proposed Insured has requested a later date.

RETURN OF MONEY. If any of the above conditions are not met, the liability of FCSLA will be limited to the return of the amount remitted with this receipt. All returns will be made without interest to or for the benefit of the owner.

AGREEMENT. I agree that: (1) the limited amount of insurance that may begin prior to certificate delivery will not exceed the Maximum Amount as described above; (2) this temporary amount of insurance is contingent upon the Conditions that are listed being met exactly; (3) this receipt will be void if the application or this receipt contains any material misrepresentation or the Proposed Insured dies by suicide; and (4) this receipt will be of no legal effect on and after the earliest of the following: (a) the date the entire amount remitted with this receipt is returned, or (b) the date a certificate is issued to the Owner.

_____

Signature of Proposed Insured Date of this Receipt Signature of Owner (if other than Proposed Insured)

Received from: _____the sum of _____

Paid with an application to First Catholic Slovak Ladies Association on the life of _____, Proposed Insured.

This Conditional Receipt is not valid unless: (1) it bears the same date as the date of the application; (2) the amount shown in this receipt is the same as the amount shown in the application; and (3) it is signed by the agent or representative who received the payment.

I have accurately represented the terms and conditions of this receipt to the Proposed Insured and Owner. I know of no reason why the Proposed Insured may not be eligible for insurance.

_____

Signature of Agent or Representative

First **Catholic** Slovak Ladies **Association**

24950 Chagrin Blvd., Beachwood, OH 44122 • (800) 464-4642 • www.fcsla.org

Non-Conforming Life Illustration Acknowledgment

An illustration is defined as a sales presentation or depiction that includes non-guaranteed elements of a certificate over a period of years. This form must be signed by the sales representative and applicant/owner, and submitted with any life insurance application that is not accompanied by a signed illustration matching the application.

Applicant's Name *(please print)*: _____

Representative's Name *(please print)*: _____

I, the Applicant, hereby acknowledge that *(check only one)* :

☐ I viewed a computer screen illustration, but no hard copy of the illustration was furnished. I understand that an illustration, matching the screen illustration, will be provided to me no later than the time the application is submitted to the home office. The screen illustration included the certificate information listed below:

Product Illustrated: _____

Gender: Male / Female **Age:** _____ **Tobacco Usage:** Yes / No

Substandard Rating: _____ **Dividend Option:** _____

Death Benefit: $ _____ **Premium:** $_____

Contact me by mail, fax, or email at: _____

☐ The certificate applied for is different from the illustration shown to me, and I understand that an illustration conforming to the certificate as issued will be provided no later than at the time the certificate contract is delivered.

☐ No illustration was provided to me and I understand that an illustration conforming to the certificate as issued will be provided no later than the time the certificate contract is delivered.

_____

Signature of Applicant Date

_____

Signature of Representative Number Date

A signed copy of this form must be provided to the Applicant and the Home Office

PLEASE ATTACH TO APPLICATION

The First Catholic Slovak Ladies Association of the USA
Beachwood, OH 44122

Office of the FCSLA Medical Examiner

Comments:

FCSLA Medical Examiner. Date.

DO NOT WRITE IN THIS SECTION - FOR HOME OFFICE USE ONLY.

Certificate Mailed to: _____Owner _____ Insured _____Agent _____Other:_____.

Date Mailed: _____ By:_____.