

Home Office Use Only			
Approved for Membership Category:			
P	F	N/E	Init _____

MEMBERSHIP ELIGIBILITY

Full Name: _____

- 1) Are you currently a member of FCSLA? _____ Yes _____ No
- 2) Are you of Slovak or Slavic descent **AND** Catholic? _____ Yes _____ No
- 3) Is your spouse of Slovak or Slavic descent **AND** Catholic? _____ Yes _____ No
- 4a) Are you a family member of an existing FCSLA Member? _____ Yes _____ No
- 4b) If Yes, indicate the full name of your family member _____

Please Print Clearly

- 5) Are you a Christian who is following your belief? _____ Yes _____ No

The Association has two membership categories: Principal and Fraternal. The above questions are used to determine the category for which you qualify. Fraternal members are entitled to all the Association's fraternal benefits, are not able to have voting privileges at any level, and are not eligible to hold office at any level.

I hereby apply for membership in the First Catholic Slovak Ladies Association and affirm that I am a citizen of the United States of America, and sound in body and mind. I declare that the above answers are correct to the best of my knowledge and belief.

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

Date

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 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: M / F **Age:** _____ **Tobacco Use:** Y / N **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 Proposed Insured

Date

Signature of Representative

Number

Date

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

First Catholic Slovak Ladies Association
Of the United States of America

24950 Chagrin Blvd, Beachwood, OH 44122
 800-464-4642 Please print in black or blue ink

SHORT APPLICATION for INDIVIDUAL LIFE INSURANCE

Branch #: _____

Is the Proposed Insured a member of First Catholic Slovak Ladies Association? Yes No. If not, apply for membership.

PROPOSED INSURED:

Name _____

Maiden Name if Female _____

Street Address _____

City _____ State _____ Zip _____

Gender: Male Female U.S. Citizen: Yes No

Primary Phone(_____) _____

Email Address _____

Social Security Number _____ - _____ - _____

Date of Birth ____/____/____ Age _____

Plan of Insurance _____

Amount of Insurance \$ _____

Payment mode _____

Amount paid with application \$ _____

Payor Name: _____

Payor Street Address: _____

Payor City: _____ State _____ Zip _____

Dividend option if participating: Check Accumulate
 Paid-up additions Reduce Premium

Automatic Premium Loan? Yes No

OWNER INFORMATION:

Name _____

Street Address _____

City _____ State _____ Zip _____

Phone (_____) _____

Relationship to insured _____

Social Security Number _____ - _____ - _____

BENEFICIARY INFORMATION:

Name _____

Street Address _____

City _____ State _____ Zip _____

Relationship to insured _____

Social Security Number _____ - _____ - _____

(For additional beneficiaries, please include a separate sheet with the same information requested above, then date and sign.)

PLEASE ANSWER THIS ONE HEALTH RELATED QUESTION:

1) Yes No In the last 5 years, has the Proposed Insured received, or is now receiving medical or surgical care or treatment for:

- cancer, tumor or malignancy; diabetes, heart or circulatory disease or disorder;
- high blood pressure; alcohol or drug abuse; enlarged lymph nodes; stroke; epilepsy, mental or nervous disease or disorder;
- or disease of the blood, kidneys, liver, lung, stomach or intestines or immune system?

If the answer is yes, please contact the Home Office at 800-464-4642 Ext. 1062.

2) Yes No Has the Proposed Insured used tobacco in any form during the past 12 months?

3) Yes No Does the Proposed Insured have any existing life insurance policies or annuity contracts with our company or any other company? Amount? _____

4) Yes No Will the coverage applying for change or replace any existing life insurance or annuity for the Proposed Insured? If yes, please list name of insurer and amount of insurance: _____

FRAUD WARNING: 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.

AGREEMENT: I represent that my statements and answers 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.

It is understood and agreed, no insurance shall take effect unless and until: this application is approved at our Home Office, not through acceptance of application by agent; 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: _____ this _____ day of _____, 20_____

AGENT'S STATEMENT: To the best of your knowledge and belief, will the insurance applied for replace or change any existing insurance or annuity?
 Yes No

 Agent/Witness Signature Agent ID#

 Agent/Witness Printed Name NPN #

 Proposed Insured's signature
 (Parent or Guardian if under age 16)

 Signature of Owner, if Owner is other than Proposed Insured

Addendum to Life Insurance Application

The following questions are added as an addendum to the life insurance application form. They are part of the application.

1. Does any person named as Beneficiary or Contingent Beneficiary lack an Insurable Interest* in the person to be insured?
Yes ____ No ____ If yes, please explain. _____
2. Is any portion of the premium on the policy applied for to be paid in whole or in part through an assumption and/or forgiveness of a loan to fund premiums?
Yes ____ No ____ If yes, please explain. _____

*Insurable Interest is a connection by blood of the beneficiary to the insured; or an economic connection under which the beneficiary stands to suffer financial loss by reason of the death of the insured.

Sales Material Verification

Regarding Application in the Name of: _____
(Please print full name)

I hereby affirm that I have used in conjunction with this sale only sales materials that have been approved by First Catholic Slovak Ladies Association.

Further, I affirm that copies of all sales materials were left with the applicant.

Single Premium Whole Life Modified Endowment Contract Acknowledgment

The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) established a classification of life insurance policies termed, "modified endowment contracts". TAMRA alters the tax treatment of distributions received from modified endowment contracts. A life insurance policy (certificate) is classified as a modified endowment contract if the premiums paid over the first seven years of the policy exceed an amount established by Congress.

If you are applying for a Single Premium Whole Life, that certificate is a modified endowment contract (exceptions may apply if the certificate is being funded entirely by a 1035 exchange of a non MEC certificate). As a result of this classification, you should be aware that:

1. if there is gain in the certificate, the portion of the gain included in any distribution (including certificate loans, full or partial surrenders, assignments, pledges, withdrawals or loans secured by the certificate) will be reported as taxable income;
2. if such a distribution occurs prior to the insured attaining age 59 1/2, the taxable portion of the distribution may also be subject to a 10% tax penalty;
3. taxable distributions are reported by FCSLA to the IRS; and
4. the cash value of a Modified Endowment Contract will accumulate income tax free. In addition, death benefits will be income tax free to any named beneficiary (not to the insured's estate).

Please contact your tax professional regarding the tax consequences of a modified endowment contract.

I have read the above explanation concerning Modified Endowment Contracts. I understand that the certificate I have applied for may be a Modified Endowment Contract and I agree to accept the certificate on that basis. I understand, and my FCSLA agent has advised me, that First Catholic Slovak Ladies Association assumes no responsibility for the tax consequences of any particular transaction and that I should consult my own tax advisor to determine the tax implications of any situation.

Ohio Insurance Guaranty Association Disclosure Statement

FIRST CATHOLIC SLOVAK LADIES ASSOCIATION OF THE UNITED STATES OF AMERICA IS LICENSED TO DO BUSINESS IN THE STATE OF OHIO. AS A NOT-FOR-PROFIT, TAX-EXEMPT, MEMBERSHIP ORGANIZATION, FRATERNAL BENEFIT SOCIETIES ARE NOT INCLUDED IN THE OHIO 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.

Signature of Proposed Insured _____

Signature of Agent _____