First Catholic Slovak Ladies Association
A Fraternal Benefit Society
24950 Chagrin Boulevard, Beachwood Ohio 44122
800.464.4642

Application for Life Insurance

Pennsylvania 2009
1. Proposed Insured

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Last</td>
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<tr>
<td>Middle</td>
<td></td>
</tr>
<tr>
<td>Suffix</td>
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<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
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<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Sex:</th>
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<td><em><strong>/</strong></em>/_____</td>
<td>___</td>
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</table>

<table>
<thead>
<tr>
<th>Maiden Name if Female:</th>
<th>Driver's License Number:</th>
<th>Employer:</th>
<th>Occupation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>________________________</td>
<td>_________</td>
<td>__________</td>
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</table>

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

<table>
<thead>
<tr>
<th>Plan Name/Type:</th>
<th>Face Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>_____________</td>
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</table>

<table>
<thead>
<tr>
<th>Additional Benefits/Riders:</th>
<th>Amount Paid with Application:</th>
</tr>
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<tbody>
<tr>
<td>___________________________</td>
<td>____________________________</td>
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</table>

<table>
<thead>
<tr>
<th>Mode:</th>
<th>Modal Premium:</th>
</tr>
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<tbody>
<tr>
<td>____Annual</td>
<td>$______________</td>
</tr>
<tr>
<td>____Semi-Annual</td>
<td></td>
</tr>
<tr>
<td>____Quarterly</td>
<td></td>
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<tr>
<td>____Monthly</td>
<td></td>
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<tr>
<td>____Single.</td>
<td></td>
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<table>
<thead>
<tr>
<th>Electronic Fund Transfer (if applicable)</th>
<th>Automatic Premium Loan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____Yes</td>
<td>_____No.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Certificate to be Dated:</th>
<th>Dividend option, if participating:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><strong>/</strong></em>/_____</td>
<td>(check one)</td>
</tr>
<tr>
<td><strong><strong><strong>/</strong></strong></strong>/______</td>
<td>(check one)</td>
</tr>
<tr>
<td>______________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Purchase Paid-Up Additional Life Insurance</th>
<th>Accumulate</th>
<th>Cash</th>
<th>Reduce Premium.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Recommended)</td>
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<td></td>
<td></td>
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</tbody>
</table>

3. Owner Information (If other than Proposed Insured)

<table>
<thead>
<tr>
<th>Owner Name:</th>
<th>Social Security Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________</td>
<td>_______________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Relationship to Insured:</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>--------------------------</td>
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</table>

| Telephone #: | |
|--------------||
| (______)____| |

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

<table>
<thead>
<tr>
<th>Primary:</th>
</tr>
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<tbody>
<tr>
<td>__________</td>
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<table>
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<tr>
<th>Contingent:</th>
</tr>
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<tbody>
<tr>
<td>____________</td>
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</table>

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. ____________________________________________
### 6. Underwriting Information

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong> Lung disease, asthma, pleurisy, recurrent pneumonia, emphysema, chronic cough, or tuberculosis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>b)</strong> Sugar, albumin, blood or pus in the urine, kidney stone, any disease or disorder of the kidney, bladder, prostate, reproductive or genito-urinary system?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>c)</strong> Diabetes, goiter; cancer or tumor; skin lesion, Kaposi’s Sarcoma, abnormal growth of any kind, disorder of the lymph glands or endocrine disorder?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>d)</strong> 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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>e)</strong> 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)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>f)</strong> Stomach or duodenal ulcer, hernia, chronic indigestion, GERD, any disease or disorder of the esophagus, stomach, intestines, rectum, liver, or gall bladder?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>g)</strong> Eye or ear disease or disorder?</td>
<td></td>
<td></td>
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<tr>
<td><strong>h)</strong> Gout, rheumatism, arthritis, spine or back disease or disorder, multiple sclerosis, disorder of the muscles or bones?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>i)</strong> Sexually transmitted disease or disorder including but not limited to syphilis, gonorrhea, hepatitis B or genital herpes?</td>
<td></td>
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<tr>
<td><strong>j)</strong> Alcoholism or the excessive use of alcohol, or the use of any controlled substance?</td>
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<tr>
<td><strong>k)</strong> Any disease or disorder not listed above? (See 7a for AIDS/ARC/HIV.)</td>
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</table>

### 7. Additional Underwriting questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a)</strong> 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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>b)</strong> 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?</td>
<td></td>
<td></td>
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<tr>
<td><strong>c)</strong> Has the Proposed Insured been arrested or convicted for any criminal offense; or is currently on parole or probation?</td>
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<tr>
<td><strong>d)</strong> 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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>e)</strong> Has the Proposed Insured used tobacco in any form during the past 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>f)</strong> 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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>g)</strong> Has the Proposed Insured ever: had an application for life insurance declined, postponed, modified; or been charged an increased premium?</td>
<td></td>
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<tr>
<td><strong>h)</strong> Does the Proposed Insured have plans to travel or reside outside the United States within the next 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>i)</strong> 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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>j)</strong> 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.</td>
<td></td>
<td></td>
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</tbody>
</table>
The First Catholic Slovak Ladies Association of the USA
Beachwood, OH 44122

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.__________________________________________
Address.____________________________________________________________
City._________________ State._________________ Zip._____________________

Specialist Name.______________________________________________________
Address.____________________________________________________________
City._________________ State._________________ Zip._____________________

Telephone Number.___________________________________________________
Telephone Number.___________________________________________________

Date and reason for last consultation and results, treatment and/or medication recommended:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
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 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 Alaska, Arizona, Kansas, Kentucky, Nebraska, Pennsylvania, West Virginia and other states not listed below: Any person who knowingly and with 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 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 Alaska, Arizona, Kansas, Kentucky, Nebraska, Pennsylvania, West Virginia and other states not listed below: 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 Insured's Signature. (If Proposed Insured is an adult, age 18 or older, and is the Applicant.)

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

Agent/Witness Signature. Agent ID#.

Adult Applicant Signature. (If Proposed Insured is not an adult, under Age 18.)

Agent/Witness Printed Name.
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.
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**

*(If Proposed Insured is an adult, Age 18 or older, and is the Applicant.)*

**Witness.**

**Adult Applicant Signature**

*(If Proposed Insured is not an adult, under the Age 18.)*

**Additional Remarks:**
Authorization for Release of Health-Related Information to FCSLA Life

Name of Patient/Proposed Insured (please print)  Date of Birth (MM/DD/YYYY)  Former/Maiden Name (If applicable)

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record to FCSLA Life. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) Infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

By signing below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that FCSLA Life may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; 5) evaluate potential insurance applications with FCSLA Life subsidiaries and affiliates to which I have applied or may apply for coverage; and 6) conduct other legally permissible activities that relate to any coverage I have or have applied for with FCSLA Life.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to FCSLA Life at 24950 Chagrin Blvd, Beachwood, OH 44122. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that FCSLA Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that information disclosed to FCSLA Life pursuant to this Authorization is no longer covered by the HIPAA Privacy Rule, and that in the course of conducting its business, FCSLA Life may release information that it has about me to affiliates, reinsurers, and any person performing business or legal services for FCSLA Life as permitted or required by law.

I understand that if I alter, revoke, or refuse to sign this Authorization to release my entire medical record, FCSLA Life may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I further understand that My Providers cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. I acknowledge by my signature below, that I have a right to receive, and have in fact received, a copy of this Authorization.

________________________________________  ________________________________
Signature of Patient/Proposed Insured  Date Signed (MM/DD/YYYY)
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 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 __________________________

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”) stipulates that only a principal member may hold office at any level and have voting privileges at any level. 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:

Be a Premier Fraternal Benefit Society that offers quality financial products and benefits.

Mission Statement:

We provide financial security to our members while embracing our Catholic values and Slavic traditions.

Form No. ME 2015
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.

I authorize The First Catholic Slovak Ladies Association of the USA, or its reinsurers, to make a brief report of my personal health information to MIB.

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.

MIB-2012
NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy’s cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are canceling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action or terminate or alter your existing life insurance until you have been issued the new policy, examined it and have found it acceptable to you.

Name of Insured

____________________________________

Existing Insurance Company

____________________________________

Policy Number

____________________________________

Date

__________________________________

Applicant’s Signature

__________________________________

Date

__________________________________

Agent’s Signature

________________________________________________________________________
NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

Definition: Replacement is any transaction where, in connection with the purchase of new insurance or annuity coverage, you lapse, surrender, convert to paid-up insurance, place on extended term, reduce benefits or term of coverage, reduce cash value or borrow all or part of the policy loan values on an existing insurance policy or annuity.

In connection with the purchase of this coverage, IF YOU HAVE REPLACED OR INTEND TO REPLACE your present life insurance or annuity coverage, you should be certain that you understand all of the relevant factors involved.

You should BE AWARE that you may be required to provide evidence of insurability and

1. If your HEALTH condition has CHANGED since the application was taken on your present policies, you may be required to pay ADDITIONAL PREMIUMS under the NEW POLICY, or be DENIED COVERAGE.

2. Your present occupation or activities may not be covered or could require additional premiums.

3. The INCONTESTABLE and SUICIDE CLAUSE will begin anew in a new policy. This could RESULT in a CLAIM under the new policy BEING DENIED that would otherwise have been paid.

4. Current law DOES NOT require your present insurer(s) to REFUND any premiums.

5. It may be to your advantage to OBTAIN INFORMATION regarding your existing policies from the insurer or agent from whom you purchased the policy. Your existing company will provide this information to you.

CAUTION: If after studying the information available to you, you decide to replace your existing life insurance or annuity coverage with our policy, you are urged not to take any action to terminate or alter your existing coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance or annuity coverage for which you have applied, you may find yourself unable to purchase other life insurance or annuity coverage or be able to purchase it only at substantially higher rates.

INSURANCE COMPANY INSURER’S MAILING DATE:

________________________________________________________________________________________
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

CR 0809
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.

_________________________________________ Date
Signature of Applicant

_________________________________________ 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

FCNCIA-06
SALES MATERIAL VERIFICATION

NOTICE TO FIRST CATHOLIC SLOVAK LADIES ASSOCIATION:

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.

______________________________________________________________  __________
Signature of Agent        Date

Printed Name of Agent __________________________

Agent Number _________________________________

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

SMV  White – Home Office Copy  •  Pink – Agent Copy  •  Yellow – Applicant Copy
03/2007
Whole life Modified Endowment Contract Acknowledgement

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.

The certificate you are applying for 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 ½, 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 is 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.

Signature of Applicant ___________________________________________ Date ____________________________

Signature of Agent________________________________________________ Date ____________________________

************************************************************************** Please submit with application**************************************************************************
Whole Life Modified Endowment Contract Acknowledgement

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 (“MECs”). A life insurance policy (certificate) is classified as a MEC if the premiums paid over the first seven years of the policy exceed an amount established by Congress.

The certificate you are applying for may be a MEC (exceptions may apply if the certificate is being funded entirely by a 1035 exchange of a non-MEC certificate). With regards to certificates that are MECs, 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 ½, 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 MEC 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 MEC.

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.

Signature of Applicant _______________________________________ Date __________________________

Signature of Agent__________________________________________ Date _________________________

************************************************ Please submit with application ***********************

M-10-2020
ELECTRONIC FUNDS TRANSFER (EFT) DEBIT AUTHORIZATION

For Life Insurance Premiums

Premiums on your life insurance certificate may be paid electronically if your financial institution is a member of the National Clearing House Association (NACHA). Electronic Funds Transfer is the fast, easy, and safe way to pay your FCSLA premiums. Please allow up to two months to process this enrollment request before automatic premium payments begin.

Payor Information:
Name (print): ____________________________
Address: __________________________________
SSN: ____________________________
EMail: ____________________________
DOB: ____________________________

FCSLA Certificate Information:
Certificate Number: (leave blank if new application)
Payment Transfer Day:
☐ 5th ☐ 10th ☐ 15th ☐ 20th
☐ Monthly ☐ Semi-Annually
☐ Quarterly ☐ Annually

Payor Bank Information:
Bank Name (print): 
Bank Routing Number: 
Bank Account Number: 
☐ Checking (Attach voided check) ☐ Savings (Attach Bank Authorization)

Yes, enroll me in FCSLA's EFT to pay my premiums!
Authorized signature(s) ____________________________ Phone Number ( ) Date __________

I authorize FCSLA to electronically transfer funds from my account identified above, to pay premiums due on my life insurance certificate on the dates indicated above. If my scheduled day is not a business day, I understand that my request will post on the following business day. I understand that sufficient funds must be kept in my account to cover these premiums. I understand that I may cancel or change this authorization by mailing written notice to FCSLA. FCSLA reserves the right to refuse or terminate automated deposit services.

A VOIDED BLANK CHECK OR BANK AUTHORIZATION MUST BE RETURNED WITH THIS FORM to the Home Office.

Any questions, please call the Billing Department at extension 1067.