POLISH NATIONAL UNION of AMERICA

referred to as the PNU - A Fraternal Benefit Society
[1002 Pittston Avenue Scranton, Pa 18505]
[1-800-724-6352 or 570-344-1513]

ADULT INSURANCE APPLICATION

1. Is the Proposed Insured now a member of the PNU?
☐ Yes ☐ No
If "No" please apply for membership.

2. Full name of Proposed Insured.

3. Address of Proposed Insured (include Zip + 4)

4. Date of Birth: _____ Age: _____
Place of Birth: _____
Gender: ☐ Male ☐ Female
Marital Status: ☐ Not Married ☐ Married

5. Social Security No.

6. Telephone No. (____) _____
E-mail

7. Occupation (Describe duties)

8. Applicant (if other than Proposed Insured)
Name: _____
Relationship: _____
Social Security No. _____
Address: _____

9. Mailing and Billing information
Mail Bill to ☐ Applicant ☐ Proposed Insured
Mail Official Publication to
☐ Applicant's address
☐ Proposed Insured's address

10. Has the proposed insured ever been declined, postponed or rated up for life insurance?
☐Yes ☐No

11. Is any application for any other life insurance on the life of the proposed insured now pending or contemplated? ☐Yes ☐No

12. Life insurance and annuities in force on Proposed Insured

Company	Year Issued	Plan	Amount

13. Will insurance being applied for replace or change any existing insurance coverage with the PNU or any other company?
☐Yes ☐No

14. Plan of insurance _____

Amount of insurance $

15. Premium payment frequency:
☐Annual ☐Semiannual ☐Quarterly ☐Monthly
☐Single Payment ☐Other

16. Dividend options:
☐ Paid-up additions ☐ Cash

17. Beneficiary or beneficiaries, with right of revocation, to whom proceeds shall be payable in equal shares in the event of death.

Primary beneficiaries — Relationship to insured
. _____
. _____
. _____
. _____

Contingent beneficiaries — Relationship to insured
. _____
. _____
. _____
. _____

18. Provide any additional details to questions on page 1.

19. State any special requests here.

Fraud Warning

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 fradulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Home Office Use Only

Certificate No.	Branch No.	Date Admitted	First Dues Payment Due		

Date Received _____ Date of Processing _____

Second Date Received _____ Second Date of Processing _____

Medical Director Approval (when required) _____Date_____

Medical Director Check one: Standard ¨ Sub Standard ¨_____ Reject ¨

Approved for issue _____ Date _____

Questions 20 thru 34 apply to the Proposed Insured only.

20. What is the Proposed Insured's height? feet inches	
21. What is the Proposed Insured's weight? pounds	
22. Has the Proposed Insured gained any weight in the past year? a. If "Yes" how much ? lbs. List the reason.	☐Yes ☐ No
23. Has the Proposed Insured lost any weight in the past year? a. If "Yes" how much ? lbs. List the reason.	☐Yes ☐ No
24. Does the Proposed Insured have a family history of diabetes, cancer, melanoma, heart or kidney disease, mental illness or suicide, or any hereditary disease?	☐Yes ☐ No
25. Has the Proposed Insured sought or received counseling or treatment for alcohol or drug use, dependency, addiction or abuse?	☐Yes ☐ No
26. In the last 10 years has the Proposed Insured: a. used marijuana, cocaine, heroin, amphetamines or hallucinogens? b. used any tranquilizers, sedatives, or narcotic drugs? c. used legally prescribed drugs in excess of dosages prescribed by a physician or medical practitioner?	 ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No
27. In the last 10 years has the Proposed Insured ever been in a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation, or treatment?	☐Yes ☐ No
28. In the past 5 years has the Proposed Insured had any diagnostic studies (X-ray, electrocardiogram, blood tests (except for AIDS/ARC), or any other) ?	☐Yes ☐ No
29. Has the Proposed Insured ever been diagnosed by a licensed physician as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related-Complex (ARC), HIV or any other disease of the immune system?	☐Yes ☐ No
30. In the past 10 years has the Proposed Insured ever had or been told they had: **(If answer is "Yes", circle all conditions that apply and provide additional details in #35 below)**	
a. dizziness, fainting spells, epilepsy, loss of conciousness, nervous breakdown, mental illiness, strokes, or any disease or disorder of the brain or nervous system?	☐Yes ☐ No
b. asthma, emphysema, hay fever, chronic cough, pleurisy, spitting of blood, tuberculosis, or any disease or disorder of the lungs or respiratory system?	☐Yes ☐ No
c. any disease or disorder of the heart or blood vessels?	☐Yes ☐ No
d. stomach or duodenal ulcer, any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver, gall bladder, pancreas or spleen, nephreitis, kidney stone, or any disease of the kidneys, bladder or prostate?	☐Yes ☐ No
e. gout, arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints or muscles?	☐Yes ☐ No
f. rheumatic fever, high blood pressure, angina pectoris, chest pain or discomfort, shortness of breath, heart murmur, swelling of legs or ankles, or any disease or disorder of the heart or blood vessels?	☐Yes ☐ No
h. varicose veins, phlebitis, anemia, or any disease or disorder of the blood or glands?	☐Yes ☐ No
i. any tumor or disease of the breast or reproductive organs?	☐Yes ☐ No
j. any abnormality, deformity, disease or disorder not listed above?	☐Yes ☐ No
31. Is the Proposed Insured receiving treatment or taking medication of any kind?	☐Yes ☐ No
32. Is the Proposed Insured now pregnant? If "Yes" how long? _____ Not Applicable ☐	☐Yes ☐ No
33. Has the Proposed Insured consulted or been treated or examined by a physician or practitioner for any cause not recorded above within the last 5 years?	☐Yes ☐ No
a. If "Yes" then when? _____ b. By whom? _____ c. Full address. _____ d. Reason for consultation.	
34. Has the Proposed Insured smoked one or more cigarettes, cigars, or pipes, or chewed tobacco or snuff in the last 12 months?	☐Yes ☐ No

35. Details and additional information related to questions 22 thru 34:

AGREEMENT

I understand that all of my statements and answers shall be part of the contract of insurance when and if one is issued. I declare that all such statements and answers are, to the best of my knowledge and belief, true and complete.

I understand that no contract of insurance will be in effect until it is issued and delivered by the PNU during the Proposed Insured's lifetime; the Proposed Insured must be in the same state of health as when the application was signed; and the first premium must have been paid.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

This authorization is designed to comply with the HIPPA Privacy Rule

I, the Proposed Insured, hereby authorize any health plan, health care provider or health care clearinghouse, insurer, employer, or government agency that has provided payment, treatment or services to me or on my behalf, to release to the persons or entities identified in Paragraph Number 1 below, information it has about my physical or mental health, financial position or educational achievement. Paragraph Number 2 below describes the class of persons or entities hereby authorized to release personal health information about me. These persons or entities may disclose the information described in Paragraph Number 3 below.

1. The records and information will be disclosed to **The Polish National Union of America**, 1002 Pittston Avenue, Scranton, PA 18505 and their contractors, employees, representatives, affiliates and assigns as necessary to fulfill the purpose of this disclosure.
2. **Persons or entities hereby authorized to disclose personal health information about me:** Any health plan, physician, surgeon, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit manager, medical facility or medically related facility, insurance company, workers compensation insurer, reinsurance company, insurance support organization (such as the Medical Information Bureau, Inc. (MIB)), or other health care provider, the Veterans Administration, the Social Security Administration, a consumer reporting agency, financial institution, educational institution and employer.
3. **Description of the information that may be disclosed:** This authorization specifically includes the release of my entire medical record and any other protected health information concerning me including without limitation office notes, including those that describe a diagnosis, prognosis or response to treatment; results of all diagnostic tests; surgical notes; notes describing treatments provided, prescribed or recommended; history of prescriptions for pharmaceuticals; and all other information in your custody or control about any medical care or treatment provided to me. This authorization specifically includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV), sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco. Any financial, employment or personal information requested for insurance purposes may also be disclosed.

The purpose of this disclosure is an application for life insurance coverage or to evaluate a claim for benefits on behalf of the Proposed Insured.

The **Polish National Union of America** may re-disclose information to reinsurance companies, to MIB, or their representatives, or to others who perform business or legal services related to the application or the policy or claim there under; in which case it may not be protected under federal privacy rules. Information will not be released to anyone else unless required or permitted by law or unless further authorized.

- This authorization is good, as needed, for 30 months from the date signed or while a claim is open, if longer.
- I agree that a photocopy or facsimile of this authorization may be used the same as the original.
- I acknowledge that I have read this Authorization and received a copy of it.
- I understand that I may revoke this Authorization by sending written notice to the Polish National Union of America. Actions taken in reliance on this Authorization will not be affected, but no further actions will be taken in reliance on this Authorization after revocation is received by the Polish National Union of America. Revocation of this Authorization may result in the refusal to pay benefits under a policy that has been issued.
- I understand that if I choose not to give or revoke authorization to release information to the PNU I will still be able to receive treatment and benefits that I am entitled to as long as the information is not needed to determine eligibility for the treatment and benefits.

Signature of Proposed Insured _____ Date _____

Signature of Applicant (if other than Proposed Insured) _____ Date _____

Signature of Member Applicant (if Proposed Insured is not a member of PNU) _____ Date _____

DECLARATION OF AGENT

Is the insurance applied for intended to replace any existing insurance or annuity policies now in force? ☐Yes ☐ No

Agent's State License No. _____ State Licensed in _____ Telephone No. _____ Branch No. ____

Agent's name(print) _____ Signature _____ Date _____

Organizer's name(print) _____ Signature _____ Date _____

POLISH NATIONAL UNION of AMERICA

Medical Examination Report

Must be completed by a licensed medical professional when required.

1. Height ft. in. Did you measure?	☐Yes ☐ No
2. Weight lbs. Did you weigh?	☐Yes ☐ No
3. Pulse seated _____ Is pulse irregular?	☐Yes ☐ No
a. If "yes" describe and where applicable give the number of irregularities before and after exercise sufficient to increase pulse rate to 100 or more.	
4. Blood Pressure: Please record all readings. With Hypertension or if first reading is over 135 systolic or 85 daistolic take two additional readings. First Reading: Systolic _____ Diastolic_____ Second Reading: Systolic Diastolic	
a. Is diastolic at disappearance of all sound?	☐Yes ☐ No
b. Is diastolic at change of sound?	☐Yes ☐ No
5. Do you find any evidence of past or present disease: | **Provide Details to "Yes" answers**	
a. of the heart and blood vessels? _____	☐Yes ☐ No
1. Is there a murmur? _____	☐Yes ☐ No
2. Is there any hypertrophy? _____	☐Yes ☐ No
3. Is there any arteriosclerosis? _____	☐Yes ☐ No
b. of the lungs? _____	☐Yes ☐ No
c. of any of the abdominal organs? _____	☐Yes ☐ No
d. of the skin, breasts, ears, middle ears, eyes, throat?	☐Yes ☐ No
6. Is there any enlargement of the Thyroid? _____	☐Yes ☐ No
a. Is it symmetrical, asymmetrical, nodular, or diffuse?	☐Yes ☐ No
7. Are the lymph nodes enlarged?	☐Yes ☐ No
8. Is there a hernia? _____	☐Yes ☐ No
a. Was it ever strangulated?	☐Yes ☐ No
9. Is there any evidence of varicose veins or ulcers? _____	☐Yes ☐ No
a. Do they extend above the knee?	☐Yes ☐ No
10. Is Proposed Insured lame, maimed, or deformed?	☐Yes ☐ No
11. Does the Proposed Insured's appearance indicate good health?	☐Yes ☐ No
12. Were the circumstances under which you completed examination satisfactory?	☐Yes ☐ No
13. Are you in any way related to the Proposed Insured or agent? _____	☐Yes ☐ No
a. If "Yes" to which one are you related and how?	
14. Are you aware of anything about the health, habits, environment, or mode of life of the Proposed Insured which might unfavorably affect insurability? _____	☐Yes ☐ No
15. Do you have knowledge of the Proposed Insured ever being diagnosed by a licensed physician as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), Aids-Related-Complex (ARC), HIV or any other disease of the immune system?	☐Yes ☐ No

URINALYSIS

Specific Gravity?	Reaction?
Albumin?	Test Used?
Sugar?	Test Used?
Are you satisfied that the specimen is the Proposed Insured's?	☐Yes ☐ No

Examiner's Statement

I have carefully examined _____ this _____ day of _____, 20___

Examination was made in private at ☐my office ☐residence of Proposed Insured ☐place of business of Proposed Insured.

Signature of Examiner _____

Print name of Examiner _____

Examiner's address - street and number _____

city, state, zip code _____