

POLISH NATIONAL UNION of AMERICA

Questions 18 thru 27 apply to the Proposed Insured only.

1002 Pittston Avenue Scranton, Pa 18505
800-724-6352 or 570-344-1513

20. If less than 1 year old, was Proposed Insured premature? Yes No

21. To the best of your knowledge and belief has the Proposed Insured:

a. any birth injury or do you know of any congenital or hereditary abnormality, disease, or trait which may affect the Proposed Insured's future health? Yes No

b. consulted with or been treated by a physician or other practitioner during the past 5 years? Yes No

22. Has the Proposed Insured ever been diagnosed by a licensed physician as having been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related-Complex (ARC), HIV or any other disease of the immune system? Yes No

23. Who is the usual medical attendant (family doctor or pediatrician) for the Proposed Insured? Please give full name and address .

24. What is the date Proposed Insured last consulted or was examined by the usual medical attendant? _____

25. What is the reason for last consultation or examination by the usual medical attendant?

Family Record

26.	Full Name	Age	If Living, State of Health	Age at Death	If Deceased, Cause of Death
	Father				
	Mother				
	Other children in family:				

27. Does Proposed Insured live with applicant? Yes No

a. If "No" with whom does the Proposed Insured live? _____
b. If "No" what is their relationship to the Proposed Insured? _____
c. If "No" provide complete address of relation named in 27 a. _____

28. Details and additional information related to questions 18 thru 27:

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AGREEMENT

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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's parent or legal guardian, 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 the Proposed Insured, to release to the persons or entities identified in Paragraph Number 1 below, information it has about the Proposed Insured's 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 the Proposed Insured. 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 the Proposed Insured: 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 the Proposed Insured's entire medical record and any other protected health information concerning the Proposed Insured 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.

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

Signature of Applicant _____ Date _____

Signature of Proposed Insured's Parent or Legal Guardian _____ 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 _____

