

**Use for Age
0 thru 15
ONLY**

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]
JUVENILE INSURANCE APPLICATION

**Use for Age
0 thru 15
ONLY**

<p>1. Full name of Proposed Insured. _____</p>	<p>12. Plan of insurance _____</p> <p>Amount of insurance \$ _____</p>																
<p>2. Address of Proposed Insured (include Zip + 4) _____</p>	<p>13. Premium payment frequency: <input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Single Payment <input type="checkbox"/> Other</p>																
<p>3. Date of Birth: _____ Age: _____ Place of Birth: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>14. Dividend options: <input type="checkbox"/> Paid-up additions <input type="checkbox"/> Cash</p>																
<p>4. Social Security No. _____</p>	<p>15. Beneficiary or beneficiaries, with right of revocation, to whom proceeds shall be payable in equal shares in the event of death.</p> <p style="text-align: center;"><u>Primary beneficiaries</u> <u>Relationship to insured</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p style="text-align: center;"><u>Contingent beneficiaries</u> <u>Relationship to insured</u></p> <p>_____</p> <p>_____</p> <p>_____</p>																
<p>5. Telephone No. (____) _____ E-mail _____</p>																	
<p>6. Applicant (if other than Proposed Insured) Name: _____ Relationship: _____ Social Security No. _____ Address: _____</p>																	
<p>7. Mailing and Billing information Mail Bill to <input type="checkbox"/> Applicant <input type="checkbox"/> Proposed Insured Mail Official Publication to <input type="checkbox"/> Applicant's address <input type="checkbox"/> Proposed Insured's address</p>	<p>16. Provide any additional details to questions on page 1. </p>																
<p>8. Has the Proposed Insured ever been declined, postponed or rated up for life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>17. State any special requests here. </p>																
<p>9. Is any application for any other life insurance on the life of the Proposed Insured now pending or contemplated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																	
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Company</th> <th style="width:20%;">Year Issued</th> <th style="width:20%;">Plan</th> <th style="width:30%;">Amount</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Company	Year Issued	Plan	Amount													<p style="text-align: center;">Fraud Warning</p> <p>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 such person to criminal and civil penalties.</p>
Company	Year Issued	Plan	Amount														
<p>11. Will insurance being applied for replace or change any existing insurance coverage with the PNU or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																	

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 <input type="checkbox"/> Sub Standard <input type="checkbox"/> Reject <input type="checkbox"/>	
				Approved for issue _____ Date _____	

POLISH NATIONAL UNION of AMERICA

Questions 18 thru 27 apply to the Proposed Insured only.

18. What is the Proposed Insured's height? _____ feet _____ inches	
19. What is the Proposed Insured's weight? _____ pounds	

20. If less than 1 year old, was Proposed Insured premature?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. consulted with or been treated by a physician or other practitioner during the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	

POLISH NATIONAL UNION of AMERICA

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'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.

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 _____

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Weight lbs.	Did you weigh?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Pulse seated _____	Is pulse irregular?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 diastolic take two additional readings. First Reading: Systolic _____ Diastolic _____ Second Reading: Systolic _____ Diastolic _____		
a. Is diastolic at disappearance of all sound?		<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is diastolic at change of sound?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you find any evidence of past or present disease: Provide Details to "Yes" answers		
a. of the heart and blood vessels? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
1. Is there a murmur? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is there any hypertrophy? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is there any arteriosclerosis? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
b. of the lungs? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
c. of any of the abdominal organs? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
d. of the skin, breasts, ears, middle ears, eyes, throat?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is there any enlargement of the Thyroid? _____		
a. Is it symmetrical, asymmetrical, nodular, or diffuse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are the lymph nodes enlarged?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is there a hernia? _____		
a. Was it ever strangulated?		<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is there any evidence of varicose veins or ulcers? _____		
a. Do they extend above the knee?		<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is Proposed Insured lame, maimed, or deformed?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Does the Proposed Insured's appearance indicate good health?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Were the circumstances under which you completed examination satisfactory?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are you in any way related to the Proposed Insured or agent? _____		
a. If "Yes" to which one are you related and how?		<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Are you aware of anything about the health, habits, environment, or mode of life of the Proposed Insured which might unfavorably affect his insurability? _____		
		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No

URINALYSIS

Specific Gravity?	Reaction?
Albumin?	Test Used?
Sugar?	Test Used?
Are you satisfied that the specimen is the Proposed Insured's?	
<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____