KSKJ LIFE, AMERICAN SLOVENIAN CATHOLIC UNION
A Fraternal Benefit Society
APPLICATION FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
815-741-2001 www.kskjlife.org

Proposed Insured: First:_____ M.I.:_____ Last:_____

Residence Address: Street and Number: _____City:_____ State:_____ Zip:_____

Personal Information: Date of Birth: Mo: ___Day: __Year: ___ Height: ____Weight:_____ Home Phone: (___) ____- _____

Occupation And Duties: _____ Average Annual Earnings: $ _____

Employer: Name and Address: _____

Beneficiary: _____ Relationship:_____

Address: _____

Policy Owner:_____ Relationship:_____

Address:_____ _____

Is the applicant a member of KSKJ Life? ❑ Yes ❑No If "No" applying for membership? ❑ Yes ❑No

Benefits Requested: Accidental Death and Dismemberment

Benefit Amount Requested: $ _____

Modal Premium$: _____ **Amount paid with this application** $_____

Mode: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ACH/Bank-draft (Submit authorization and 2 months premiums)

Please Answer All The Questions

1. Have you ever been diagnosed or treated by a physician for:
   - **a)** A physical medical defect? …… ❑Yes ❑No
   - **b)** Any sight or hearing defect? ……..……..…… ❑Yes ❑No
   - **c)** Any nervous or mental condition, epilepsy, fainting episode, blackout, fit or paralysis of any kind? ❑Yes ❑No
   - **d)** High blood pressure, a heart condition, rheumatic fever or diabetes? ……..……..…… ❑Yes ❑No
   - **e)** A "slipped disc" of other spinal disorder, a hernia or any rheumatic or arthritic condition? ..... ❑Yes ❑No
2. Have you ever been declined or accepted on special terms for life, accident or illness insurance? …. ❑Yes ❑No
3. Do you participate in any hazardous sports or avocations? …… ❑Yes ❑No
   If "yes," ***please provide details below:***
4. Do you participate in any aviation activities other than on regularly scheduled airlines? …… ❑Yes ❑No
   If "yes," ***please complete an aviation questionnaire.***

Details:

Agreement & Authorization: I represent, to the best of my belief, that all statements and answers contained in this application are complete and true. I expressly agree that no insurance is in effect as a result of this application unless: (a) the application is approved by the Company; and (b) a policy has been issued by the Company; and (c) the policy has been manually received and accepted by the Owner; and (d) the first modal premium has been paid; all during the lifetime and continued insurability of the Proposed Insured. I hereby authorize any licensed physician, hospital, clinic or other medical or medically-related facility, insurance company, or consumer reporting agency, or the Medical Information Bureau, that has any records or knowledge of the Proposed Insured's health, to give KSKJ Life, American Slovenian Catholic Union or its reinsurers any such information and records pertaining to medical, psychiatric, drug use or alcohol use history. A copy of this authorization shall be considered as valid as the original and shall be valid for a period of 30 months. I acknowledge receipt of the Medical Information Bureau's Pre-Notice and Federal Fair Credit Reporting Act.

Signed at:_____ Date:_____ _____
Proposed Insured's Signature

Owner:_____ By:_____
(if other than proposed insured) Signature of Owner

AUTHORIZATION - This authorization complies with the HIPAA Privacy Rules

_____ _____-_____-_____ _____
Name of proposed insured (please print) Social Security Number Date of birth (MM/DD/YY)

_____ _____ (_____)_____
Address City, State Zip Phone Number

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 5 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to KSKJ Life, American Slovenian Catholic Union and its agents, employees, and representatives. 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, but excludes psychotherapy notes for specific purposes listed below. I also authorize any Pharmacy or Pharmacy Benefit Manager; Consumer Reporting Agency; Employer; Institution; Organization; or, Person; and, the Medical Information Bureau (MIB), who may have any records or information regarding me and, if so indicated below, the my minor children, to provide such records or information to: KSKJ Life; its reinsurer; the MIB, or its legal representative. KSKJ Life may, at its discretion, obtain an investigative consumer report.

The undersigned understands that any records or information obtained will: be used, with the exception of MIB, to determine eligibility for insurance or benefits; and, be treated as confidential. However, KSKJ Life or its reinsurer may release any such records or information to: the MIB; other insurers to whom you may apply for insurance or submit a claim; or, as may be lawfully required.

Specific description of health information to be used or disclosed:

_____

(e.g. if not specifically limited or restricted, the types of information to be used or disclosed may include medical, psychiatric, or psychological records, records of evaluation and treatment for alcohol or drug abuse, records and results of HTLV-III, HIV , or AIDS testing, etc.)

Approximate dates of treatment:

_____

Purpose of the use or disclosure:

_____

Purpose or organizations using or disclosing the information: KSKJ Life, American Slovenian Catholic Union

Persons or organizations receiving the information:_____

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. This protected health information is to be disclosed under this Authorization so that KSKJ 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; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with KSKJ Life.

This authorization shall remain in force for 30 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 KSKJ Life at 2439 Glenwood Ave., Joliet, IL 60435-5490, Attention: Underwriting Dept. 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 KSKJ Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, KSKJ Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

This Authorization includes the minor children of the Proposed Insured: ☐ Yes. ☐ No

Signed at_____ _____
City/State Date

_____ _____
Proposed Insured (Age 18 or older) Owner (if other than Proposed Insured)

_____ _____
Agent Signature and Agent No Adult Applicant (Parent/Legal Guardian) and/or Member Applicant
(Applicable in Pennsylvania Only)

The Fraud Warning Notice is included below. When the application is written the Notice must, by law, be detached and given to the Applicant.

PENNSYLVANIA – 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 factual material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

KSKJ LIFE, AMERICAN SLOVENIAN CATHOLIC UNION

2439 GLENWOOD AVE ♦ JOLIET, IL 60435 ♦ 815-741-2001

RECEIPT FOR PREMIUM PAID - Initial Premium Must Be Submitted with the Application

_____ $ _____ _____

Received from (print) the sum of for an application for insurance on (Name)

No insurance is in effect as a result of this application unless: (a) the application is approved by the Company; and (b) a policy has been issued by the Company; and (c) the policy has been manually received and accepted by the Owner; and (d) the first modal premium has been paid; all during the lifetime and continued insurability of the Proposed Insured.

_____ _____

Received by (Agent's Signature) Date

Notice: This receipt should be detached and given to the proposed insured only if the full modal premium is collected. Two (2) months premium required if monthly PAC.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO KSKJ LIFE, AMERICAN SLOVENIAN CATHOLIC UNION. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Detach Here

MEDICAL INFORMATION BUREAU (MIB)

Information regarding your insurability will be treated as confidential. KSKJ Life or its reinsurer may, however, make a brief report thereon to the MIB, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member for life or health insurance coverage, or if a claim for benefits is submitted to such member, the MIB will, upon request, supply such member with the information it may have in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the MIB file information, you may contact the MIB and seek a correction in accordance with procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is: MIB inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184; telephone: (866) 692-6901. The KSKJ Life or its reinsurer may also release file information to other insurers to whom you may apply for life or health insurance; or, a claim may be submitted.

(This notice must be detached and given to the Proposed Insured)