Application for Juvenile Term Insurance and Membership

Catholic Fraternal Life 2021 Mascoutah Ave PO Box 327 Belleville, IL 62222-0327

1. CHILD TO BE INSURED (Please Print)

Name First Middle Initial Last Gender M ☐ F ☐

Address (No. and Street, City, State, Zip Code)

Social Security Number Date of Birth Age Telephone

2. BENEFICIARY (Please Print)

Name First Middle Initial Last Relationship

3. I wish to apply for coverage in the amount of: ☐$10,000 ☐ $25,000 ☐$50,000

4. Will any life insurance or annuity policy be replaced or changed because of this application? ☐Yes ☐No

(If "Yes", complete required replacement form(s) and attach.)

Company ____ Policy Number ____________________

5. Do you have existing life insurance or annuity contracts with the company or any other company? ☐Yes ☐No

Details (Furnish complete name of Issuing Company, Policy Number, amount of insurance being replaced.)

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6. What is the child to be insured's current: height: _____ ft. _____ in. and weight: _____ lbs.

7. If the child has siblings, does each child have an equal amount of life insurance coverage? ☐Yes ☐No

8. Has the child to be insured ever been diagnosed or treated by a member of the medical profession for:

a. cancer ☐Yes ☐No

b. stroke ☐Yes ☐No

c. any deformity, congenital defect or abnormal development ☐Yes ☐No

d. diabetes ☐Yes ☐No

e. any heart disorders ☐Yes ☐No

f. any liver disorders ☐Yes ☐No

g. any respiratory disorders ☐Yes ☐No

h. any intestinal disorders ☐Yes ☐No

i. any urinary disorders ☐Yes ☐No

j. any mental or emotional disorders ☐Yes ☐No

k. any neurological disorders ☐Yes ☐No

9. Has the child to be insured ever been diagnosed or treated by a member of the medical profession for: any immune deficiency disorders, Acquired Immune Deficiency Syndrome, Acquired Immune Deficiency Syndrome related complex, or within the past three (3) years test results indicating exposure to the Acquired Immune Deficiency Syndrome virus? ☐Yes ☐No

10. Has the child received any medical advice, examination, or treatment other than regular pediatric examinations, immunization shots or treatment for childhood disease within the past 5 years? ☐Yes ☐No

11. Provide details for any question 6 through 9 that was answered "Yes".

12. APPLICANT/OWNER (Please Print)

Name First Middle Initial Last Relationship to Child

____

Address (No. and Street, City, State, Zip Code)

____

Social Security Number Date of Birth Age Telephone

____

Contingent Owner (If Applicant/Owner Dies)

Name First Middle Initial Last Relationship to Child

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I am the parent, grandparent or guardian and I hereby declare that I have read the foregoing questions and represent each answer to be true and complete to the best of my knowledge and belief. I UNDERSTAND that the Company will rely on my answers and that no insurance will take effect until the premium has been paid and a certificate has been issued while the Insured is living.

FRAUD STATEMENT

I hereby acknowledge and accept the full text of the Fraud Statement as follows:
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at ______________________________________ X ______________________________

City State Date Applicant/Owner Signature

CONDITIONAL RECEIPT

All premium checks must be made payable to CATHOLIC FRATERNAL LIFE

RECEIVED FROM ______________________________THIS ________ DAY OF ____________________20______.

THE SUM OF $________________ in connection with an application for Juvenile Term Life Insurance in the Amount of

$____________________ as shown on the application on ______________________________, the Proposed Insured.

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Signature of Licensed Agent