

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 <input type="checkbox"/> F <input type="checkbox"/> |
| 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.)

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

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.

Catholic Fraternal Life 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.

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.

Signature of Licensed Agent