ISDA FINANCIAL LIFE
Life Insurance and Annuities

ISDA FRATERNAL ASSOCIATION
A Fraternal Benefit Society
419 Wood Street | Pittsburgh | PA | 15222
Ph: 412.261.3550 or 800.457.4732
www.orderisda.org

# APPLICATION FOR FINAL EXPENSE LIFE INSURANCE

## PROPOSED INSURED

| Name (First, Middle Initial, Last) | Sex ☐Male ☐ Female | Social Security No. | | |
|---|---|---|---|---|
| Home Address (Street, City, State, Zip) | | State of Birth | Date of Birth | Age |
| Home Phone No. | Are the Proposed U.S. citizen's? ☐ Yes☐ No | ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated | | |
| Cellular Phone No. | Driver's License No. | Driver's License State | | |
| Email | Height | Weight | Weight change in the last 12 months? Please provide details, if applicable: _____ Gain _____ Loss | |
| Employer | Employer Address | | | |
| Duties and occupation | Years employed | | | |
| **In the past 12 months,** has the Proposed Insured used any form of tobacco including vaping, or nicotine replacement therapy? ☐Yes ☐ No | Are you a legal resident of the United States? ☐Yes ☐ No (If "**No**", you are **NOT** eligible for coverage.) | | | |

## OWNER (Complete only if Owner/Applicant is different from Proposed Insured)

| Name of Policyowner (First, Middle Initial, Last) | Relationship to Proposed Insured | | | |
|---|---|---|---|---|
| Policyowner Address (Street, City, State, Zip) | Phone No. | Social Security No. | | |
| Sex ☐Male ☐Female | Date of Birth | Age | E-mail | Citizenship Country |

## BENEFICIARY* (with right to change) Please complete this section in its entirety

*Unless otherwise stated, benefits are payable equally to the named beneficiaries or to the surviving beneficiaries. If benefits are payable other than equally, please indicate a contingent beneficiary for each primary beneficiary.

| Primary Beneficiary | Relationship to Insured | Date of Birth | SSN or Tax ID # |
|---|---|---|---|
| | | | |
| | | | |
| **Contingent Beneficiary** | **Relationship to Insured** | **Date of Birth** | **SSN or Tax ID #** |
| | | | |
| | | | |

## PLAN INFORMATION

| | |
|---|---|
| Plan Name: _____<br>Amount Applied For $ _____<br>Risk Class:_____<br>Planned / Modal Premium:_____ | Riders<br>□ Accidental Death Benefit $_____<br>□ Other $_____ |

Payment Mode: ☐ Direct Bill ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (Automated Bank Account withdrawal)

Modal Premium $ _____ Collected Premium $ _____

Policy Notes:

## OTHER COVERAGE INFORMATION

| | |
|---|---|
| 1) Does the Proposed Insured have any existing life insurance contracts or pending applications with the company or any other company? | ☐ Yes ☐ No |
| 2) Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with the company or any other company? | ☐ Yes ☐ No |

Provide details to all **Yes** answers:

**NOTE: If the Proposed Insured answers all questions below in sections 1 and 2 "No", that person is eligible for the Level benefit coverage.**

## UNDERWRITING QUESTIONS

**SECTION ONE- If the Proposed Insured answers "Yes" to any questions in Section One, that person is NOT eligible for any Level Benefit or Graded Benefit coverage under this application.**

| | |
|---|---|
| 1) Is the Proposed Insured currently:<br>(A) Requiring any of the following other than for fractures, and bone or joint surgery: electric scooter, wheelchair, or oxygen equipment to assist breathing excluding use for sleep apnea? | ☐ Yes ☐ No |
| (B) Confined or bedridden to a hospital, long-term care facility, nursing home, or home health care? | ☐ Yes ☐ No |
| (C) Requiring assistance with daily living activities such as bathing, dressing, toileting, eating, bowel or bladder issues, getting out of bed? | ☐ Yes ☐ No |
| 2) Has the Proposed Insured ever been:<br>(A) Diagnosed with, treated for, or advised by a licensed professional health care professional for Dementia, Sickle Cell Anemia, Huntington's Disease, Down's Syndrome, mental incapacity, Cirrhosis, Gehrig's Disease, congestive heart failure, Myelodysplastic Syndrome(MDS), Quadriplegic, or Paraplegic? | ☐ Yes ☐ No |
| (B) Diagnosed by a licensed health care professional with diabetic coma, insulin shock, or had an amputation due to diabetic complications? | ☐ Yes ☐ No |
| (C) Diagnosed by a licensed health care professional with End Stage Renal Disease or requiring dialysis? | ☐ Yes ☐ No |
| (D) Diagnosed by a licensed health care professional with a terminal illness with an expected result of death within the next 12 months? | ☐ Yes ☐ No |
| (E) Tested positive for exposure to the HIV infection HIV antibodies in a test taken for the purpose of obtaining insurance or whether the applicant has been diagnosed by a physician as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? | ☐ Yes ☐ No |
| (F) Advised to receive or have received an organ or bone marrow transplant? | ☐ Yes ☐ No |
| 3) In the past 2 years, has the Proposed Insured been diagnosed with, treated for, or advised by a health care professional to receive treatment for any form of cancer? | ☐ Yes ☐ No |

| | |
|---|---|
| 4) In the past 12 months, has the Proposed Insured been:<br>(A) Diagnosed by a health care professional as having heart disease or in need of heart surgery? | ☐ Yes ☐ No |
| **SECTION TWO - - If the Proposed Insured answers "Yes" to any questions in Section Two, that person is only eligible for the Graded Benefit Coverage.** | |
| 1) In the past 4 years, has the Proposed Insured: received care or treatment for, or been advised by a licensed medical professional to seek treatment for:<br>(A) Systemic Lupus or Scleroderma, Chronic Kidney Disease? | ☐ Yes ☐ No |
| (B) Bipolar Depression, Parkinson's Disease, Schizophrenia or Multiple Sclerosis? | ☐ Yes ☐ No |
| (C) Leukemia, Cancer, Melanoma or any other internal cancer | ☐ Yes ☐ No |
| 2) In the past 2 years, has the Proposed Insured:<br>(A) Been treated for or advised by a licensed medical professional to have treatment for alcohol abuse? | ☐ Yes ☐ No |
| (B) Been treated for or advised by a licensed medical professional to have treatment for drug abuse? | ☐ Yes ☐ No |
| (C) Convicted more than once of driving under the influence of drugs or alcohol? | ☐ Yes ☐ No |
| (D) Used unlawful drugs in any form or abused or misused prescription drugs? | ☐ Yes ☐ No |
| (E) Been convicted of a felony? | ☐ Yes ☐ No |
| (F) Currently awaiting trial for a felony? | ☐ Yes ☐ No |
| 3) In the past 2 years, has the Proposed Insured been hospitalized by a licensed medical professional for any mental or nervous disorder? | ☐ Yes ☐ No |
| 4) In the past 2 years, has the Proposed Insured been advised by a licensed medical professional to seek treatment, or received care for:<br>(A) Stroke or Transient Ischemic Attack (TIA)? | ☐ Yes ☐ No |
| (B) Heart Attack, Coronary Artery Bypass Surgery, Coronary Artery Disease, Angioplasty, irregular heart rhythm, Cardiomyopathy, or Valvular Heart Disease with surgical repair or replacement? | ☐ Yes ☐ No |
| 5) In the past 12 months, has the Proposed Insured consulted a licensed medical professional for unexplained weight loss greater than 10 pounds, fatigue, chronic cough, or unexplained gastrointestinal bleeding? | ☐ Yes ☐ No |
| 6) Has the Proposed Insured ever received care, treatment for, or been advised by a licensed medical professional to seek treatment for:<br>(A) Hepatitis C? | ☐ Yes ☐ No |
| (B) Chronic Bronchitis, Sarcoidosis, Chronic Lung Disease including Chronic Obstructive Pulmonary Disease(COPD), or Emphysema? | ☐ Yes ☐ No |
| (C) Diabetes prior to age 50 or diabetes at any age with complications of Retinopathy (eye), Neuropathy (nerve) , Nephropathy (kidney), or Peripheral Vascular Disease (PVD or PAD)? | ☐ Yes ☐ No |

**COMMENTS – Not Required – Please provide any additional information available.**

| Section Number | Question Number & Letter | Please give specific details to Underwriting Questions about Dates, Procedures, Medications, or any other important information that may be needed. Exclude any information regarding HIV,AIDS, or ARC. |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## AGREEMENT

It is understood and agreed as follows:

1) The statements and answers recorded in all parts of this application are true and complete, to the best of my knowledge and belief.
2) No information regarding any proposed Insured will be considered known by the Association unless explicitly set out in writing on this application.
3) This application and the answers to any required medical exam will become a part of any policy issued on it.
4) No agent has the authority to waive any of the Association's rights or rules or to make or change any contract.
5) The insurance applied for will take effect only after the following occur while the proposed Insured(s) is(are) living and his/her(their) health is as stated in this application: (1) the policy is delivered to, and accepted by, the Owner; and (2) the first full premium is paid in cash. The only exception to this is provided in the Conditional Receipt if it has been issued and the advance payment required by the Conditional Receipt has been made.
6) I(We) have received the Notice of Information Practices which explains my(our) rights under the Fair Credit Reporting Act.
7) I(We) have paid $_____ * to the agent in exchange for the Conditional Receipt and I(we) acknowledge that I(we) fully understand and accept its terms.

***All premium checks must be made payable to ISDA Fraternal Association. Do not make the check payable to the agent or leave the payee blank.**

***By signing this application, you certify that you have completely read and fully understand the above statements.***

Do you understand that with the approval of this application, you will be a member of the ISDA Fraternal Association as well as the Order Italian Sons and Daughters of America? ☐ **Yes** ☐ **No**

Insured's Signature **X** _____ the_____ day of _____, 20_____

City_____ State_____

_____ _____

Agent's Name | Proposed Insured's Name

**X**_____ **X** _____

Agent's Signature | Proposed Insured's Signature

_____ _____

Florida License ID number | Proposed Insured's Address

_____ _____ _____

Sponsor | Lodge No. | Secondary Addressee Name

_____

Secondary Addressee's Address

Secondary Addressee: For the purpose of notification of a past due premium payment and possible lapse in coverage.

## FRAUD WARNING

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

## TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

**X**_____
**Primary Insured's Signature**

**X**_____
**Owner's Signature**
**(if other than Primary Insured)**

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, Association, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

## STATEMENT OF AGENT

By signing below, I/we, the Agent(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

1. I/We certify that, during an interview with the Proposed Insured, I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. ☐ **Yes** ☐ **No**
2. Do you, the Agent(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy or annuity contract in force with the company or any other company? ☐ **Yes** ☐ **No**
3. Has the Proposed Insured informed you, the Agent(s), that he/she has any pending or existing life insurance or annuity contracts with the company or any other company? ☐ **Yes** ☐ **No**
4. Are you related to the Proposed Insured or owner? ☐ **Yes** ☐ **No**

   If yes, please state the relationship. _____
5. How long have you known the Proposed Insured? _____
6. How long have you known the Proposed Owner? _____
7. Previous residence of Proposed Insured for the past five years.

   Address_____

   Address_____

   Address_____
8. I conducted the interview in person. ☐ **Yes** ☐ **No**

   If no, please explain _____

_____ _____

Agent's Name Agent's E-mail

**X**_____ _____

Signature of Agent Date

I certify that the statements of the Primary Insured, and Owner have been correctly recorded in this application and that any premium payment shown on page 4 has been collected by me and that a Conditional Receipt has been given to the Primary Insured/Owner. ☐ Yes ☐ No

To the best of my knowledge, the insurance applied for in this application ☐will ☐will not replace existing insurance.

| | | | |
|---|---|---|---|
| _____ | **X**_____ | _____ | _____ |
| Printed Name of Writing Agent | Signature of Writing Agent | Split % | Agent # |
| _____ | **X**_____ | _____ | _____ |
| Printed Name of Writing Agent | Signature of Writing Agent | Split % | Agent # |
| _____ | **X**_____ | _____ | _____ |
| Printed Name of Writing Agent | Signature of Writing Agent | Split % | Agent # |
| _____ | **X**_____ | _____ | _____ |
| Printed Name of Writing Agent | Signature of Writing Agent | Split % | Agent # |

# AUTHORIZATION FOR THE RELEASE OF PERSONAL AND MEDICAL INFORMATION

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**NOTICE TO PROPOSED INSURED**

I understand that information regarding insurability will be treated as confidential. ISDA or its reinsurer(s), may, however make a brief report of my personal health information to MIB, Inc., a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should I apply to another MIB member Association for life or health insurance coverage or a claim for benefits is submitted to such an Association, MIB, upon request, will supply such Association with the information it may have about you in its files. ISDA or its reinsurer(s) may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. (Medical information will be disclosed to my attending physician only). If you question the accuracy of the information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

**AUTHORIZATION**

I authorize ISDA, or its reinsurers, to make a brief report of my personal health information to MIB.
I further hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, MIB Inc., ("MIB"), ScriptCheck or other organization, institution or person, that has any records or knowledge of me, my health, or my driving record to give ISDA, or its representatives, including Equifax or bearer, or reinsurer, any such information. I understand that may include information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs and alcoholism, mental health, prescription history, medications prescribed, including information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, or other information ISDA requires to determine insurability, underwriting, eligibility for benefits, investigate claims, or support the business operations of ISDA. ISDA may disclose such information to its reinsurer(s) MIB, Inc. The applicant or a duly authorized representative of the applicant is entitled to a copy of this authorization. This authorization is valid for 24 months after the date shown below. A photographic copy of this authorization shall be as valid as the original. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent ISDA has acted in reliance on this authorization. Notice of revocation may be sent, in writing, to ISDA at the address above.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization, and that information, once disclosed, may not be protected by Federal rules governing privacy and confidentiality.

I understand that I may refuse to sign this authorization. I understand that if I refuse to sign this authorization, ISDA may not be able to process my application for life insurance for which I am applying.

**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.**

_____ _____
Name of Proposed Insured (*please print*) Date of birth

_____ _____
Signature of Proposed Insured or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Insured

## HOME OFFICE COPY

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I further hereby authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance company, MIB Inc., ("MIB"), ScriptCheck or other organization, institution or person, that has any records or knowledge of me, my health, or my driving record to give ISDA, or its representatives, including Equifax or bearer, or reinsurer, any such information. I understand that may include information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs and alcoholism, mental health, prescription history, medications prescribed, including information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, or other information ISDA requires to determine insurability, underwriting, eligibility for benefits, investigate claims, or support the business operations of ISDA. ISDA may disclose such information to its reinsurer(s) MIB, Inc. The applicant or a duly authorized representative of the applicant is entitled to a copy of this authorization. This authorization is valid for 24 months after the date shown below. A photographic copy of this authorization shall be as valid as the original. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent ISDA has acted in reliance on this authorization. Notice of revocation may be sent, in writing, to ISDA at the address above.

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_____ _____
Name of Proposed Insured (*please print*) Date of birth

_____ _____
Signature of Proposed Insured or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Insured

## PROPOSED INSURED'S COPY

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# CONDITIONAL RECEIPT

Received from:_____

this_____ day of _____ , 20____ the sum of $_____, in connection with an application for life insurance. Plan name and details _____

This receipt will be valid if payment is made by draft, check, money order or note which is not paid in full when presented for payment by ISDA. No other form of receipt for advance payment or premium will be recognized by ISDA. Please notify ISDA if, within 30 days after the date of this receipt, you have not received: (1) the contract applied for, or (2) a refund of the amount paid.

***Make all remittances payable to ISDA Fraternal Association. Do NOT make payable to agent or leave the payee blank. This receipt is not valid unless: signed by an agent of ISDA Fraternal Association.***

**X**_____ ___/___/_____
***Signature of Authorized Agent*** ***Date***

_____
***Agent's Name (Print)***

***If payment is made with application, this receipt must be given to applicant, otherwise it must be detached.***

## LEAVE WITH PROPOSED INSURED