



APPLICATION FOR SIMPLIFIED LIFE INSURANCE

PROPOSED INSURED									
Name (First, Middle Initial, Last)				Sex <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	
<input type="checkbox"/> Single	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				Are you a legal resident of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> 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: _____
 Amount Applied For \$ _____
 Risk Class: _____
 Planned / Modal Premium: _____

Riders:

- Other \$ _____
 Accidental Death Benefit \$ _____
 Waiver of Premium \$ _____
 Paid-Up Addition \$ _____
 Children's Term \$ _____

1. Child's Name: _____
 2. Child's Name: _____
 3. Child's Name: _____
 4. Child's Name: _____

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

Modal Premium \$ _____ Collected Premium \$ _____

EVIDENCE OF INSURABILITY- INSURANCE HISTORY

1) Do any of the proposed Insureds currently have life insurance coverage contract(s)? Yes No

If Yes, fill out the table below for life insurance coverage; if No, proceed to question 2) directly below the table. Please indicate the Type of coverage: Personal (P); Business (B); or Key Person (K)

Proposed Insured/Children	Association	Insurance Amount	Year Issued	Type	Replacement
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

2) Have you ever applied for life, health, or disability insurance and been declined, postponed, rated, modified or charged an increased premium? (If Yes, provide further information in the space provided.) Yes No

Provide details to all **Yes** answers:

UNDERWRITING QUESTIONS

Has the Proposed Insured been treated or diagnosed for the following by a licensed medical professional:

- Asthma, emphysema, or other lung or respiratory disease or disorder?
- Any disease or disorder of the brain or Nervous system?
- Kidney disease, diabetes, or other disease or disorder of the genito-urinary system?
- High blood pressure, chest pain, rheumatic fever, heart disease, or other circulatory disease, or disorder?
- Ulcer, disease or disorder of the stomach, Liver, or intestines?
- Tumor or any malignancy?
- Deformity, lameness, or, any physical or mental impairment?
- Any surgical operations?
- Any other injury, disease or disorder in the past five years?

- Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

Has the Proposed Insured in the last 5 years:

- Had an electrocardiogram, X-ray, blood study, or other diagnostic test?
- Been under observation, care or treatment in any: hospital, sanitarium, or, other institution?
- Been diagnosed with any disease or disorder of the breast or reproductive organs?

- Yes No
 Yes No
 Yes No
 Yes No

Is the Proposed Insured Pregnant?

If yes, how far along? _____ Months

Do you have other applications for life or health insurance now pending?

Have your applications for life or health insurance ever been: declined, postponed, or modified?

- Yes No
 Yes No

If **YES** to any questions above, please give details about illness or injury, dates, names and address of doctors and hospitals. (Please print)

Proposed Insured Doctor’s Information

1. Child Physicians Name	Address	Phone Number	Last Seen
_____	_____	_____	_____
2. Child Physicians Name	Address	Phone Number	Last Seen
_____	_____	_____	_____
3. Child Physicians Name	Address	Phone Number	Last Seen
_____	_____	_____	_____
4. Child Physicians Name	Address	Phone Number	Last Seen
_____	_____	_____	_____

Insured(s) answered YES to any Underwriting Questions, please explain in detail.

Please list any information or comments below.

Child #1

Child #2

Child #3

Child #4

Primary Insured

Physicians Name

Address

Phone Number

Last Seen

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 _____
Agent's Signature

X _____
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
(if under 15, parent/guardian signature)

X _____

Owner's/Trustee'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.

- | | |
|---|--|
| <p>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.</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>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?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>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?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>4. Are you related to the Proposed Insured or owner?
If yes, please state the relationship. _____</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>5. How long have you known the Proposed Insured? _____</p> | |
| <p>6. How long have you known the Proposed Owner? _____</p> | |
| <p>7. Previous residence of Proposed Insured for the past five years.
Address _____
Address _____
Address _____</p> | |
| <p>8. I conducted the interview in person.
If no, please explain _____</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

_____ Agent's Name	_____ Agent's E-mail
X _____ Signature of Agent	_____ Date

I certify that the statements of the Primary Insured, Owner, and any other proposed Insured(s) have been correctly recorded in this application and that any premium payment shown in item on page 2 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.

_____ Printed Name of Writing Agent	X _____ Signature of Writing Agent	_____ Split %	_____ Agent #
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AUTHORIZATION FOR THE RELEASE OF PERSONAL AND MEDICAL INFORMATION



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

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

AUTHORIZATION FOR THE RELEASE OF PERSONAL AND MEDICAL INFORMATION



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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

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