



APPLICATION FOR INDIVIDUAL FINAL EXPENSE 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 <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Other \$ _____
Payment Mode: <input type="checkbox"/> Direct Bill <input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: (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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(B) Confined or bedridden to a hospital, long-term care facility, nursing home, or home health care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(C) Requiring assistance with daily living activities such as bathing, dressing, toileting, eating, bowel or bladder issues, getting out of bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Has the Proposed Insured ever been: (A) Diagnosed with, treated for, or advised by a 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(B) Diagnosed by a health care professional with diabetic coma, insulin shock, or had an amputation due to diabetic complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(C) Diagnosed by a health care professional with End Stage Renal Disease or requiring dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(D) Diagnosed by a health care professional with a terminal illness with an expected result of death within the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(E) Diagnosed as having AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic), Acquired Immune Deficiency Syndrome (AIDS), or been treated for AIDS, ARC, or HIV by a physician or health care professional?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(F) Advised to receive or have received an organ or bone marrow transplant by a member of the Medical Profession?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

4) In the past 12 months, has the Proposed Insured been: (A) Diagnosed by a health care professional as having heart disease or in need of heart surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(B) Advised by a health care professional to have surgical operation, diagnostic testing other than routine screening for purposes related to AIDS, treatment, hospitalization, or any other procedures that the results are still pending?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 medical professional to seek treatment for: (A) Systemic Lupus or Scleroderma, Chronic Kidney Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(B) Bipolar Depression, Parkinson’s Disease, Schizophrenia or Multiple Sclerosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(C) Leukemia, Cancer, Melanoma or any other internal cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) In the past 2 years, has the Proposed Insured: (A) Been treated for or advised by a medical professional to have treatment for alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(B) Been treated for or advised by a medical professional to have treatment for drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(C) Convicted more than once of driving under the influence of drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(D) Used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(E) Been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(F) Currently awaiting trial for a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) In the past 2 years, has the Proposed Insured been hospitalized by a medical professional for any mental or nervous disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) In the past 2 years, has the Proposed Insured been advised by a medical professional to seek treatment, or received care for: (A) Stroke or Transient Ischemic Attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) In the past 12 months, has the Proposed Insured consulted a medical professional for unexplained weight loss greater than 10 pounds, fatigue, chronic cough, or unexplained gastrointestinal bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Has the Proposed Insured ever received care, treatment for, or been advised by a medical professional to seek treatment for: (A) Hepatitis C?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(B) Chronic Bronchitis, Sarcoidosis, Chronic Lung Disease including Chronic Obstructive Pulmonary Disease(COPD), or Emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

Sponsor _____

Lodge No. _____

Proposed Insured's Address _____

FRAUD WARNING

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.

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.

<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> <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> <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> <p>4. Are you related to the Proposed Insured or owner? If yes, please state the relationship. _____</p> <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> <p>_____</p> <p>Agent's Name _____ Agent's E-mail _____</p> <p>X _____</p> <p>Signature of Agent _____ Date _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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



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

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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

