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

ISDA FINANCIAL LIFE
Life Insurance and Annuities

APPLICATION FOR INDIVIDUAL SIMPLIFIED 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: _____

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.

Proposed Insured/Children	Association	Insurance Amount	Year issued	Type	Replacement
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ 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 by a member of the medical profession for:	
a. Asthma, emphysema, or other lung or respiratory disease or disorder?	☐ **Yes** ☐ **No**
b. Any disease or disorder of the brain or Nervous system?	☐ **Yes** ☐ **No**
c. Kidney disease, diabetes, or other disease or disorder of the genito-urinary system?	☐ **Yes** ☐ **No**
d. High blood pressure, chest pain, rheumatic fever, heart disease, or other circulatory disease, or disorder?	☐ **Yes** ☐ **No**
e. Ulcer, disease or disorder or the stomach, Liver, or intestines?	☐ **Yes** ☐ **No**
f. Tumor or any malignancy?	☐ **Yes** ☐ **No**
g. Deformity, lameness, or, any physical or mental impairment?	☐ **Yes** ☐ **No**
h. Any surgical operations?	☐ **Yes** ☐ **No**
i. Any other injury, disease or disorder in the past five years?	☐ **Yes** ☐ **No**
Has the Proposed Insured in the last 5 years:	
a. Had an electrocardiogram, X-ray, blood study, or other diagnostic test?	☐ **Yes** ☐ **No**
b. Been under observation, care or treatment in any: hospital, sanitarium, or, other institution?	☐ **Yes** ☐ **No**
c. Been diagnosed by a member of the medical profession with any disease or disorder of the breast or reproductive organs?	☐ **Yes** ☐ **No**
Is the Proposed Insured Pregnant?	☐ **Yes** ☐ **No**
If yes, how far along?_____ Months	
Do you have other applications for life or health insurance now pending?	☐ **Yes** ☐ **No**
Have your applications for life or health insurance ever been: declined, postponed, or modified?	☐ **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_____ **X** _____

Agent's Signature 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_____ **X**_____

Primary Insured's Signature (if under 15, parent/guardian signature)

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.

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.

   If no, please explain _____ ☐ **Yes** ☐ **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	Signature of Writing Agent	Split %	Agent #
_____	**X**_____	_____	_____
_____	**X**_____	_____	_____
_____	**X**_____	_____	_____
_____	**X** _____	_____	_____

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

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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