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.isdafinancial.com

APPLICATION FOR INDIVIDUAL 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.	U.S. Citizen? ☐ 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 Name	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	Is the Proposed Insured a legal resident of the United States? (If "**No**" you are **NOT** eligible for coverage.) ☐ Yes ☐ No			

OWNER/PAYOR (Complete only if Owner or Payor is different from Proposed Insured)

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

BENEFICIARY (With Right to Change)

Primary Beneficiary Name(s) & Relation to Insured	% Share	Date of Birth	SSN
Contingent Beneficiary Name(s) & Relation to Insured	**% Share**	**Date of Birth**	**SSN**

PLAN INFORMATION

Plan Name: _____

Amount Applied For $ _____

Risk Class (Tobacco/Non-Tobacco):_____

Automatic Premium Loan: ☐ Yes ☐ No

Riders

- ☐ Other $_____
- ☐ Accidental Death Benefit $_____
- ☐ Waiver of Premium $_____
- ☐ Paid-Up Addition $_____

Payment Mode: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly ☐ Monthly (Automated Bank Account withdrawal)

Modal Premium $ _____ **Do Not Remit Premium with Application**

Dividend Election: ☐ Paid-Up Additions ☐ Cash ☐ Reduce Premium

Policy Notes/Special Requests:

EVIDENCE OF INSURABILITY- INSURANCE HISTORY

1) Does the Proposed Insured currently have life insurance or annuity contract(s) with the Society or any other company?	☐ Yes ☐ No
2) Does the Proposed Insured intend to replace or change any life insurance or annuity contract currently in force with the Society or any other company?	☐ Yes ☐ No

If Yes, fill out the table below for life insurance coverage; if No, proceed to question 3) directly below the table. Please indicate the Type of coverage: Personal (P); Business (B); or Key Person (K)

Insurance Company Name	Insurance Amount	Year Issued	Type	Replacement
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

3) Has the Proposed Insured 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

NON-MEDICAL UNDERWRITING QUESTIONS **(Continued on Next Page)**

1) Does the proposed Insured plan to travel or reside outside the U.S. or Canada within the next 2 years? If Yes, explain here:	☐ Yes ☐ No
2) A) In the last 3 years, has the proposed Insured been convicted of or pleaded guilty to any moving motor vehicle violation or had a driver's license suspended or revoked? If Yes, explain here:	☐ Yes ☐ No
B) In the last 5 years, has the proposed Insured been convicted of or pleaded guilty to driving under the influence of alcohol or other drugs; or to careless; or reckless driving? If Yes, explain here:	☐ Yes ☐ No
3) A) In the last 3 years, has the Proposed Insured flown as a pilot; student pilot; crew member; or other than a passenger on regularly scheduled commercial airlines?	☐ Yes ☐ No
B) Is there any intent to do so within the next year?	☐ Yes ☐ No

4) In the last 3 years, has the Proposed Insured participated in or plan, in the next 2 years, to participate in skydiving; parachuting; hang-gliding; ultra-light flying; scuba diving; vehicle racing; mountain or rock-climbing; white-water rafting; bungee jumping or ice climbing?	☐ Yes ☐ No
5) Family History – Have parents or siblings of the Proposed Insured been diagnosed or treated by a licensed member of the medical profession for diabetes; cancer; heart or kidney disease; melanoma; or stroke? If Yes, please indicate below.	☐ Yes ☐ No

Relationship	Age if Living	Diagnosis or Cause of Death	Age at Diagnosis	Age at Death
Father				
Mother				
Siblings				

HEALTH STATEMENT

1) Primary Physician (provide name and address; if none, indicate none):

2) Physician last consulted (provide name; specialty; address; date last seen; and reason and results of last visit):

3) Does the Proposed Insured currently take any prescription medication? Please list here:	☐ Yes ☐ No
4) Has the Proposed Insured used any form of nicotine/tobacco products including vaping in the last 12 months? If **Yes**, provide date of last use here:	☐ Yes ☐ No
5) Does the Proposed Insured consume alcoholic beverages? If **Yes**, provide type and number of drinks per day or week here:	☐ Yes ☐ No
6) Has the Proposed Insured ever used (except as prescribed by a physician) or received treatment or counseling for the use of marijuana; heroin; cocaine; amphetamines; barbiturates; hallucinogenic agents; controlled substances; or opium or its derivatives?	☐ Yes ☐ No
7) Has the Proposed Insured ever received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol.	☐ Yes ☐ No

Has the Proposed Insured ever been diagnosed; treated; or been given advice by a licensed member of the medical profession for: (Explain yes answers in comments section below)	
8) Depression; anxiety; bipolar disorder; psychosis; schizophrenia; suicidal thoughts; eating disorder; or other nervous; mental; or emotional disorder?	☐ Yes ☐ No
9) High blood pressure; high cholesterol; heart murmur; chest pain or pressure; heart attack; irregular heart rhythm; peripheral vascular disease; palpitations; aneurysm; or any other heart or vascular disorder?	☐ Yes ☐ No
10) Anemia; blood clots; bleeding; leukemia; immune deficiency; or any other blood or immune disorder (excluding HIV)?	☐ Yes ☐ No
11) Cancer; melanoma; tumor; or other malignancy?	☐ Yes ☐ No
12) Diabetes; elevated blood sugar; or any other disorder of the thyroid or pituitary gland or the endocrine system?	☐ Yes ☐ No
13) Asthma; COPD; emphysema; bronchitis; shortness of breath; sleep apnea; tuberculosis; or any other disorder of the lungs or respiratory system?	☐ Yes ☐ No
14) Hepatitis; cirrhosis; ulcer; internal bleeding; polyps; colitis; Crohn's disease; acid reflux (GERD); or any other disorder of the stomach; liver; colon; pancreas; or digestive system?	☐ Yes ☐ No
15) A disorder of the brain; spinal cord; or nervous system; including stroke; TIA (transient ischemic attack); seizures; multiple sclerosis (MS); paralysis; tremors; fainting; chronic headaches; or loss of consciousness?	☐ Yes ☐ No
16) Protein; sugar; or blood in urine or any other disorder of the bladder or kidneys?	☐ Yes ☐ No
17) Arthritis; deformity; or any injury to or disorder of the bones; joints; muscles; back; neck; or spine?	☐ Yes ☐ No
18) Any disorder of the breasts; uterus; ovaries; cervix; prostate; or reproductive organs?	☐ Yes ☐ No
19) Menstruation; pregnancy; or complications from pregnancy?	☐ Yes ☐ No
20) Is the Proposed Insured currently pregnant? If yes, provide due date.	☐ Yes ☐ No
21) Any sexually transmitted disease or disorder?	☐ Yes ☐ No
22) Acquired Immune Deficiency Syndrome (AIDS); or tested HIV positive?	☐ Yes ☐ No
23) In the last 3 years, has the Proposed Insured had surgery; biopsy; an electrocardiogram; x-ray; blood test; or other diagnostic testing for any reason, except those related to the Human Immunodeficiency Virus (AIDS Virus), other than what you have already stated?	☐ Yes ☐ No
24) In the last 3 years, has the Proposed Insured been advised or referred by a medical professional for surgery; biopsy; medical treatment; or diagnostic testing for any reason except those related to Human Immunodeficiency Virus (AIDS Virus); that has yet to be completed?	☐ Yes ☐ No

COMMENTS – Please provide any additional information available.

Question Number	List 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.

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NOTICE REGARDING MIB, LLC. ("MIB")

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 a membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should I apply to another MIB member Company for life or health insurance coverage or a claim for benefits is submitted to such a Company, MIB, upon request, will supply such Company 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.

ISDA may disclose such information to its reinsurer(s) and MIB. I authorize ISDA, or its reinsurers, to make a brief report of my personal health information to MIB.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. 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 and the website is www.mib.com. Or you may call 866-692-6901.

AUTHORIZATION

I further authorize any licensed physician; medical practitioner; hospital; clinic or medical or medically related facility; insurance company; MIB; ScriptCheck (or other prescription drug history report) 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 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.

The applicant or a duly authorized representative of the applicant is entitled to a copy of this authorization. This authorization is valid for the time limit, if any, permitted by applicable law in the state where the contract is delivered or issued for delivery. 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.

A photographic copy of this authorization shall be as valid as the original.

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

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.

AGREEMENT

It is understood and agreed as follows:

1) The statements and answers in 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) No agent has the authority to waive any of the Association's rights or rules or to make or change any contract.
4) The insurance applied for will not take effect unless the first full premium is paid and a policy is delivered while the health of the Proposed Insured continues, without material change, as represented in this application.
5) I have been given a copy of the NOTICE REGARDING MIB.

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.

Signed at _____ This _____ Day of _____, 20____
(City, State)

X_____ **X**_____

Proposed Insured Owner, if other than Proposed Insured

_____

Lodge Number

Agent's Statement

1. To the best of my knowledge, the insurance applied for in this application ☐will ☐will not replace existing insurance.
2. 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.

X_____ **X**_____

Agent's Name (Print) Agent's Signature

_____

Agent License ID number