This is only a sample application.
It is not a promise to issue coverage.

You cannot buy this policy directly from
Royal Neighbors of America.

It is **sold only via licensed agencies** such as Choice Mutual.

To apply, call Choice Mutual
(licensed to sell Royal Neighbors of America products)
at 1-800-644-2926.

INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠
Royal Neighbors of America
230 16th Street
Rock Island, IL 61201
Toll-free (800) 627-4762
A Fraternal Benefit Society

Application for Simplified Issue Individual Whole Life Insurance

❑ Mail certificate to agent

PART 1

SECTION 1 – Proposed Insured

Name ______________________ Street ______________________
City ______________________ ST ______________ ZIP ______________
SSN/Tax ID ______________________ Sex ❑ M ❑ F
Phone ( ) ______________________ DOB __________ State/Country of birth __________
❑ U.S. driver's license ❑ Green Card ❑ Passport ❑ Other ______________________
ID number ______________ ID issuer ______________ ID expiration date ______________
Are you a U.S. citizen? ❑ Yes ❑ No If No, Permanent Resident ID # ______________________

SECTION 2 – Other Insurance

1. EXISTING or APPLIED FOR INSURANCE

Does the Proposed Insured have any existing or applied for life insurance or annuity contracts with this or any other company?

❑ Yes ❑ No **IF YES,** complete state replacement forms, if required, with this application. Provide details:

Company ______________________ ❑ Life Insurance ❑ Annuity Amount ______________

2. REPLACEMENT

In connection with this application, has there been, or will there be, with this or any other company any: replacement of coverage; surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? ❑ Yes ❑ No

IF YES, complete state replacement forms, if required, with this application.

SECTION 3 – Proposed Owner

OWNER other than PROPOSED INSURED

Name ______________________ SSN/Tax ID ______________________
Street ______________________ Phone ( ) ______________ DOB ______________
City ______________ ST ______ ZIP ______ Relationship to Proposed Insured ______________
❑ U.S. driver's license ❑ Green Card ❑ Passport Are you a U.S. citizen? ❑ Yes ❑ No
❑ Other ______________________ If No, Permanent Resident ID # ______________
ID number ______________ ID issuer ______________ ❑ Check if you wish ownership to revert to Insured upon Owner's death.*
ID expiration date ______________ * There may be tax consequences. Please consult your tax advisor.*

SECTION 4 – Beneficiary(ies)

Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.

❑ **PRIMARY** (Percent of proceeds ______%)
Name ______________________
Street ______________________
City ______________ ST ______ ZIP ______
DOB ______________ SSN/Tax ID ______________
Relationship to Proposed Insured ______________

❑ **PRIMARY** (Percent of proceeds ______%) ❑ **CONTINGENT**
Name ______________________
Street ______________________
City ______________ ST ______ ZIP ______
DOB ______________ SSN/Tax ID ______________
Relationship to Proposed Insured ______________

❑ **PRIMARY** (Percent of proceeds ______%) ❑ **CONTINGENT**
Name ______________________
Street ______________________
City ______________ ST ______ ZIP ______
DOB ______________ SSN/Tax ID ______________
Relationship to Proposed Insured ______________

❑ **PRIMARY** (Percent of proceeds ______%) ❑ **CONTINGENT**
Name ______________________
Street ______________________
City ______________ ST ______ ZIP ______
DOB ______________ SSN/Tax ID ______________
Relationship to Proposed Insured ______________

SAMPLE
FROM CHOICE MUTUAL

SECTION 5 – Information Regarding Specific Insurance Plan

1. **LIFE INSURANCE PLAN**
   ❑ Simplified Issue Whole Life ❑ Graded Death Benefit
2. **RIDER**
   ❑ Accelerated Living Benefit Rider (no additional premium; not available on face amounts below $7,000)
3. **FACE AMOUNT $**________________________
4. **AUTOMATIC PREMIUM LOAN will be provided.**
   ❑ No Check if **APL** is **NOT** desired.

SECTION 6 – Payment Information

If **Electronic Payment** is chosen, complete EFT form on page 4.

1. PAYMENT MODE (Check one)

Direct bill: ❑ Annual ❑ Semi-Annual ❑ Quarterly

Electronic payment: ❑ Annual ❑ Semi-Annual

❑ Quarterly ❑ Monthly ❑ Payment with app $__________

❑ Draft first payment Payment quoted $________________

2. BILLING ADDRESS INFORMATION

❑ Proposed Insured's address ❑ Primary Owner's address

❑ Other Premium Payor's/Alternate billing address (details below)

Name ____

Street ____

City____________________________ ST______ ZIP__________

PART 2

SECTION 1 – Physician Information

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning the present health of the Proposed Insured.

Physician name/Clinic________________________________ City___________________________ ST______ ZIP____________

List all currently prescribed medications: ____

____

____

SECTION 2 – Medical Questions

Question	Yes	No
1. Has the proposed Insured used tobacco in any form in the last 12 months?	❑ Yes	❑ No
If any answer to questions 2 through 7 is YES, the Proposed Insured is not eligible for ANY coverage.		
2. Is the Proposed Insured currently:		
a. Hospitalized, in a nursing facility, or receiving Hospice Care?	❑ Yes	❑ No
b. Confined to a wheelchair, bed, or using oxygen equipment to assist in breathing?	❑ Yes	❑ No
3. Has a member of the medical profession ever diagnosed or treated the Proposed Insured for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any immune deficiency disease; or has the Proposed Insured tested positive for the Human Immunodeficiency Virus (HIV)?	❑ Yes	❑ No
4. Has the Proposed Insured ever been diagnosed as having or been treated for:		
a. Congestive heart failure, or had or been recommended to have an organ transplant?	❑ Yes	❑ No
b. Insulin shock, diabetic coma, amputation caused by disease, or taken insulin shots prior to age 30?	❑ Yes	❑ No
c. Dementia, Alzheimer's Disease, or mental incapacity?	❑ Yes	❑ No
5. During the past 18 months has the Proposed Insured been diagnosed as having:		
a. Stroke, aneurysm, cardiomyopathy, or circulatory surgery?	❑ Yes	❑ No
b. Angina (chest pain), heart attack or failure, or heart surgery?	❑ Yes	❑ No
6. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:		
a. Internal Cancer, Melanoma, or Leukemia?	❑ Yes	❑ No
b. Cirrhosis, liver disease, kidney failure (including dialysis), chronic kidney disease, or systemic lupus?	❑ Yes	❑ No
7. During the past 18 months, has the Proposed Insured been diagnosed as having:		
a. A condition expected to result in death within 12 months?	❑ Yes	❑ No
b. Been advised by a medical professional to have any diagnostic testing which has not been completed or for which the results have not been received?	❑ Yes	❑ No
c. Been recommended by a physician to have treatment or counseling for alcohol or drug abuse?	❑ Yes	❑ No
If question 8 or 9 is YES, only Graded Death Benefit is available.		
8. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:		
a. Stroke, angina (chest pain), heart attack, or cardiomyopathy?	❑ Yes	❑ No
b. Heart or circulatory surgery (including pacemaker, heart valve replacement, bypass, angioplasty, stent implant, or any procedure to improve circulation to the heart or brain)?	❑ Yes	❑ No
9. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:		
a. Emphysema, chronic obstructive pulmonary disease (COPD), or tuberculosis (TB)?	❑ Yes	❑ No
b. Neuromuscular disease (including Multiple Sclerosis, Lou Gehrig's Disease, Epilepsy, or Parkinson's Disease)?	❑ Yes	❑ No

SAMPLE
FROM CHOICE MUTUAL

Agreement/Acknowledgement

Agreement/Disclosure: To the best of my knowledge and belief, all statements in my application for life insurance including any amendments and supplements are true and complete. I also agree that:

- My statements in the application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any certificate issued and will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors, become part of the new certificate.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in the application and amendment(s), paramedical/medical exam, and any supplement(s).
- Only authorized officers of Royal Neighbors may: a) make or change any contract of insurance; b) make a binding promise about insurance; or c) change or waive any term of an application, receipt, or certificate.
- If not a current member, I, the Proposed Insured, hereby apply to become a member of Royal Neighbors as indicated by my signature on the application. As a member, I agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors was founded more than 100 years ago.

Authorization

I, the Proposed Insured, hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical facility, insurance or reinsurance company, MIB, Inc., consumer reporting agency, division of motor vehicles, the veterans administration, or other government agency or department having information as to the diagnosis, treatment, or prognosis with respect to any physical or mental condition, or having any non-medical information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past 10 years, without restriction, to Royal Neighbors, its agents, employees, or representatives. I further authorize Royal Neighbors, or its reinsurers, to make a brief report of my personal health information to MIB. This includes information on the treatment of alcohol, drug, and tobacco abuse, and psychiatric diagnosis and treatment. **In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, to give such information to any legal representative or agent employed by Royal Neighbors.**

I understand that the protected information is to be disclosed under this authorization so that Royal Neighbors may underwrite my application for life insurance, determine my eligibility for insurance, risk rating, or certificate issuance determinations, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have applied for with Royal Neighbors. Any protected information obtained will not be released by Royal Neighbors to any person or organization EXCEPT to other divisions and/or departments of Royal Neighbors, MIB, other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted, or other persons or organizations performing business or legal services in connection with my application, insurance certificate(s), or claim for benefits or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for 24 months from the date signed if used in connection with an application for life insurance certificate, an application for reinstatement of a life insurance certificate, or a request for change in certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative is entitled to receive a copy. I understand that this authorization may be revoked by me at any time in writing, and if I refuse to sign or if I subsequently revoke this authorization, Royal Neighbors may not be able to process this application, and if coverage has been issued, may not be able to process any benefit payments. I agree that Royal Neighbors shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation at its Home Office or to the extent that Royal Neighbors has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be re-disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

NO IMMEDIATE LIFE INSURANCE COVERAGE: Royal Neighbors will have no liability under this application unless and until: a) it has been received and approved by Royal Neighbors at its Home Office; b) the certificate has been issued and delivered to the owner; c) the first premium has been paid to and accepted by Royal Neighbors (If the first premium is to be electronically drafted, then the premium has not been "paid" until honored by the financial institution.); and d) at the time of delivery and payment, the facts concerning the insurability of the Insured are as stated in this application.

SIGNATURES:

Signed at city, state ______________________ Date __________

Proposed Insured ______________________

Signed at city, state ______________________ Date __________

Proposed Owner ______________________
(If other than Proposed Insured)

SAMPLE FROM CHOICE MUTUAL

Agent's Report

Does the Proposed Insured applied for or have any existing life insurance or annuity contracts with this or any other company?
❑ Yes ❑ No **IF YES,** complete state replacement forms, if required, with this application. Provide details:
Company_______________________________ ❑ Life Insurance ❑ Annuity Amount ______________
In connection with this application, has there been, or will there be, with this or any other company any: replacement of coverage; surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? ❑ Yes ❑ No
IF YES, complete state replacement forms, if required, with this application.
Did you use only written sales material approved for use by Royal Neighbors? ❑ Yes ❑ No

Did you complete any required state disclosure statements? ❑ Yes **IF YES,** state(s): ______________________ ❑ No

Did you personally review the Owner's ID? ❑ Yes ❑ No Was the Proposed Insured with you at the time of the application? ❑ Yes ❑ No
Agent no.______________________________ Agent license no.______________________________

Certification: I certify that the information provided is true and complete.

Signature of Writing Agent ______________________________ Date ______________
Printed name of Writing Agent ______________________________

If applicable, complete and sign the following statement*(s)*:

Agent Signature______________________________ Date ______________
Agent Name ______________________________ ID Number ______________ Percent ______________
Please print

Agent Signature______________________________ Date ______________
Agent Name ______________________________ ID Number ______________ Percent ______________
Please print

INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠

Royal Neighbors of America
230 16th St., Rock Island, IL 61201
(800) 627-4762
A Fraternal Benefit Society

Authorization for Electronic Funds Transfer (EFT)

I authorize Royal Neighbors of America (Royal Neighbors) and my financial institution to initiate automatic withdrawals from my checking/savings account. This authority will remain in effect until I notify Royal Neighbors or the bank to cancel it in such time as to afford a reasonable opportunity to act on the request. I can stop payment of any withdrawal by notifying Royal Neighbors three days before my scheduled withdrawal day. Royal Neighbors reserves the option to change the method of payment to another qualifying mode after the occurrence of a transaction not honored.

❑ **Check box to use bank information from attached voided check. Form must still be signed and payment selected.**

Name of financial institution ______________________________
City ______________________________ ST ______________
Name (please print)______________________________ Phone number (   )______________
Street address/PO Box ______________________________
City ______________________________ ST______________ ZIP ______________

I would like the payment withdrawn on the __________ day of the month
OR the _____2nd _____3rd ______4th Wednesday of the month. (If nothing is selected it defaults to the 5th day of the month.)
Routing No. ______________________________ Checking account no. ______________________________
OR Savings account no. ______________________________

Debit card numbers are not acceptable.

Signature ______________________________ Date ______________

PLEASE RETURN THIS AUTHORIZATION WITH A VOIDED CHECK.

SAMPLE FROM CHOICE MUTUAL