



Final Expense Sample Application

This is a sample application, not a promise to issue coverage.

Important Notes:

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

This policy is sold only via licensed Royal Neighbors of America agencies such as Choice Mutual.

To apply, call us at  **1-800-644-2926**



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, 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?

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?

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, Other, Are you a U.S. citizen?, If No, Permanent Resident ID #, ID number, ID issuer, ID expiration date, Check if you wish ownership to revert to Insured upon Owner's death.*

SECTION 4 – Beneficiary(ies)

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

PRIMARY (Percent of proceeds %), CONTINGENT, Name, Street, City, ST, ZIP, DOB, SSN/Tax ID, Relationship to Proposed Insured



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

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



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)



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 _____ Please print ID Number _____ Percent _____

Agent Signature _____ Date _____

Agent Name _____ Please print ID Number _____ Percent _____

INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES™



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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.

