



## **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®

## Application for Simplified Issue Individual Whole Life Insurance

### SECTION 1 – Proposed Insured

Name:

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Sex  F  M SSN/TAX ID \_\_\_\_\_ DOB \_\_\_\_\_ State/Country of birth \_\_\_\_\_

Email \_\_\_\_\_

Phone number \_\_\_\_\_  Driver's license # or  State ID# \_\_\_\_\_ ST \_\_\_\_\_

Are you a U.S. citizen?  Yes  No **If No**, are you a legal U.S. resident?  Yes  No

Have you ever been convicted of a felony?  Yes  No

### Trusted Contact Person

By completing this section, you designate the person listed below as your Trusted Contact Person. The Trusted Contact Person is intended to be a resource for Royal Neighbors of America in administering and protecting your certificate and responding to possible financial exploitation or fraud.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Relationship to Certificateholder: \_\_\_\_\_

*A Trusted Contact Person is not authorized to conduct transactions on your certificate. You may change your Trusted Contact Person at any time by contacting Royal Neighbors of America.*

Do you wish to designate another person (secondary addressee) to receive copies of any past due notice of premiums?  Yes  No

Name:

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone number \_\_\_\_\_



A Fraternal Benefit Society  
230 16th Street • Rock Island, IL 61201  
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## Section 2 – Proposed Owner (If other than Proposed Insured)

Name:

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Sex  F  M SSN/TAX ID \_\_\_\_\_ DOB \_\_\_\_\_ Phone number \_\_\_\_\_

Email \_\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_

Are you a U.S. citizen?  Yes  No **If No**, are you a legal U.S. resident?  Yes  No

Ownership will automatically revert to Insured upon Owner's death unless Royal Neighbors is notified otherwise.<sup>#1</sup>

<sup>#1</sup> There may be consequences. Please consult your tax advisor.

## Section 3 – Information Regarding Insurance Applied For

**1. PAYMENT MODE** Electronic check/(EFT):  Monthly  Quarterly  Semi-Annual  Annual

Payment with application, if any \$ \_\_\_\_\_

**2. FACE AMOUNT** \$ \_\_\_\_\_

**3. PLAN: WHOLE LIFE**  Level Death Benefit  Graded Death Benefit  Guaranteed Issue (if GI only, skip Section 6)

a. If a Certificate cannot be issued as applied for, would you accept a modified rate class or plan option?  Yes  No

Graded Death Benefit Payment Amount \$ \_\_\_\_\_ Face Amount \$ \_\_\_\_\_

Guaranteed Issue Payment Amount \$ \_\_\_\_\_ Face Amount \$ \_\_\_\_\_

If applicable, I agree that if the proposed insured does not qualify for the plan above, I am applying for the best plan available from those I have selected.

**4. NONFORFEITURE OPTIONS**  Cash Surrender  Reduced Paid Up  Extended Term Insurance

**5. AUTOMATIC PREMIUM LOAN (APL)** will be provided.  Check if APL is NOT desired. If this box is checked, a loan will not be taken to pay past due premiums, and the non-forfeiture option selected will take effect.

**6. DIVIDEND OPTION**  Option 1: Paid in cash  Option 2: Left on deposit to accumulate with interest

### 7. RIDERS

Accelerated Death Benefit Rider (ADB): No additional premium charge; not available below \$7,000 face amount or with Guaranteed Issue.

Grandchild Rider

Accidental Death Benefit Rider Face Amount: \$ \_\_\_\_\_

Charitable Giving Rider (no additional premium charge): Name of Charity<sup>#2</sup> \_\_\_\_\_

<sup>#2</sup> Charity selected must comply with the Internal Revenue Code 501(c) (3) for charitable organizations. The charity must be selected from a list of pre-approved charities if specified by Royal Neighbors. Contact Royal Neighbors for this list.



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## Section 4 – Other Insurance

### EXISTING or APPLIED FOR INSURANCE

Does the Proposed Insured have any existing or applied for life insurance or annuity contracts with Royal Neighbors?  Yes  No

#### Contract 1

Contract Number \_\_\_\_\_

Face Amount \$ \_\_\_\_\_

Plan of Insurance \_\_\_\_\_

Existing or Applied For  Existing  Applied For

Year of Issue \_\_\_\_\_

Replacing?  Yes  No

Does the Proposed Insured have any existing or applied for life insurance or annuity contracts with any other company?  Yes  No

#### Contract 1

Insurance Company \_\_\_\_\_

Contract Number \_\_\_\_\_

Face Amount \$ \_\_\_\_\_

Plan of Insurance \_\_\_\_\_

Existing or Applied For  Existing  Applied For

Year of Issue \_\_\_\_\_

Replacing?  Yes  No

#### Contract 2

Contract Number \_\_\_\_\_

Face Amount \$ \_\_\_\_\_

Plan of Insurance \_\_\_\_\_

Existing or Applied For  Existing  Applied For

Year of Issue \_\_\_\_\_

Replacing?  Yes  No

#### Contract 2

Insurance Company \_\_\_\_\_

Contract Number \_\_\_\_\_

Face Amount \$ \_\_\_\_\_

Plan of Insurance \_\_\_\_\_

Existing or Applied For  Existing  Applied For

Year of Issue \_\_\_\_\_

Replacing?  Yes  No

### REPLACEMENT

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

If "Yes," complete state replacement forms, if required, with this application.

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## Section 5 – Beneficiary(ies)

**PRIMARY**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_

SSN/TAX ID \_\_\_\_\_ DOB \_\_\_\_\_ Percent of proceeds \_\_\_\_\_ %

**PRIMARY**  **CONTINGENT**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_

SSN/TAX ID \_\_\_\_\_ DOB \_\_\_\_\_ Percent of proceeds \_\_\_\_\_ %

**PRIMARY**  **CONTINGENT**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_

SSN/TAX ID \_\_\_\_\_ DOB \_\_\_\_\_ Percent of proceeds \_\_\_\_\_ %

**PRIMARY**  **CONTINGENT**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_

SSN/TAX ID \_\_\_\_\_ DOB \_\_\_\_\_ Percent of proceeds \_\_\_\_\_ %



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## Section 6 – Proposed Insured/Medical Information (skip If only applying for Guaranteed Issue)

### MEDICAL QUESTIONS

A “Yes” answer does not disqualify the applicant from all offers.

1. Are you currently prescribed oxygen, hospitalized, receiving dialysis, require a wheelchair or electric (motorized) scooter for mobility; or have you been hospitalized within past year for more than 2 weeks?  Yes  No
2. Are you currently in the care of any of the following facilities: hospice, nursing home, long term care or memory care?  Yes  No
3. Has a medical professional advised or diagnosed you as having a terminal illness with a life expectancy of 12 months or less?  Yes  No
4. In the last 12 months, have you been treated for or advised by a member of the medical profession to have surgery or any diagnostic test (excluding HIV/AIDS) that has not been completed, or been referred by a member of the medical profession to a specialist for further evaluation?  Yes  No
5. In the last 12 months, have you used any form of tobacco or nicotine products including cigarettes, chewing tobacco, e-cigarettes, cigars or vape?  Yes  No
6. In the last 10 years, have you been diagnosed, treated, or been given medical advice by a member of the medical profession or prescribed medication for: (“Diagnosed” means the initial date of when illness is identified and said illness continues to be an active diagnosis for which you are monitored.)
  - a. Congestive heart failure, heart attack, coronary artery disease, cardiomyopathy, heart surgery, pacemaker, defibrillator, stroke, TIA, or aneurysm?  Yes  No
  - b. Bipolar disorder or schizophrenia, dementia, Alzheimer’s, or memory loss?  Yes  No
  - c. Cancer (other than basal cell skin cancer), melanoma, or brain tumor?  Yes  No
  - d. Diabetes with insulin use?  Yes  No
  - e. Chronic Obstructive Pulmonary Disease (COPD), emphysema, chronic bronchitis, lung damage, lung disease or disorder?  Yes  No
  - f. Chronic kidney disease, kidney failure or disease, hepatitis B or hepatitis C, or cirrhosis?  Yes  No
  - g. Multiple sclerosis, Parkinson’s disease, or epilepsy?  Yes  No
  - h. Sickle cell anemia, systemic lupus, ALS (Lou Gehrig’s disease), or been a recipient of an organ transplant?  Yes  No
  - i. Abuse of drugs(s), prescription medication(s), or alcohol; or chronic pain lasting 6 months or longer in duration with use of narcotic pain medications?  Yes  No
7. In the last 10 years has a member of the medical profession recommended you to have, or performed an amputation of any body part due to disease (including complications of diabetes)?  Yes  No
8. Has the Proposed Insured ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?  Yes  No
9. Height \_\_\_ feet \_\_\_ inches Weight \_\_\_\_\_ lbs



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## Agreement/Acknowledgment/Disclosure

I, the Proposed Insured or Proposed Owner, if applicable, have read this application for life insurance including any amendments and supplements and, to the best of our knowledge and belief, all statements are true and complete. We also agree that:

- Statements in this application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any Certificate issued.
- This application and any amendment(s), paramedical/medical exam, and supplement(s) to this application will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors of America (Royal Neighbors), become part of the new Certificate, and any copy or electronic image of these documents are as valid as the original and may be relied upon by Royal Neighbors in determining whether to issue the insurance for which I applied.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in this application and amendment(s), paramedical/medical exam, and any supplements(s).
- Only authorized officers of Royal Neighbors have the authority to: (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.
- Corrections, additions, or changes to this application may be made by Royal Neighbors. Any such changes will be shown by Endorsement to the Application. Acceptance of a Certificate issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Proposed Owner and Proposed Insured.
- If I have agreed to accept an alternative insurance product on this application, and it is different than what I originally applied for, my signature below indicates acceptance of that insurance. Information regarding the alternative product (including plan amount, premium amount, and/or benefits), has been provided and is shown to me in this application process.
- Unless otherwise provided by a Conditional Receipt, Royal Neighbors will have no liability under this application unless and until: (a) the Application has been received and approved by Royal Neighbors at the Home Office; (b) the Certificate has been issued and delivered to the Certificateowner; (c) the first premium has been paid to and accepted by Royal Neighbors; and (d) at the time of delivery and payment, the facts concerning the insurability of the Proposed Insured are as stated in this application.
- If not a current Member, the Proposed Insured applies to become a Member of Royal Neighbors as indicated by the signature on page 7 and as a Member, agrees to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors of America was founded more than 120 years ago.
- No one has signed this application on my behalf, and I, the Proposed Insured and/or Proposed Owner, if applicable, am the individual signing this application, whether as a wet, voice, or digital signature. I understand that signing this application on behalf of someone else and applying for insurance on someone without their knowledge may constitute insurance fraud and may void the Certificate.

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## Taxpayer Identification Number Certification

Under penalties of perjury, We, the Proposed Insured and Proposed Owner, certify that:

1. My tax identification number shown on this form is my correct taxpayer identification number, and
- 2a. **Proposed Insured:** 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 dividend income; or (c) the IRS has notified me that I am no longer subject to backup withholding; and

**Check this box if the IRS has notified you that you are subject to backup withholding.**

- 2b. **Proposed Owner:** I am not subject to backup withholding because (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividend income; or (c) the IRS has notified me that I am no longer subject to backup withholding; and

**Check this box if the IRS has notified you that you are subject to backup withholding.**

3. I am U.S. person (includes U.S. resident alien), and

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

**FRAUD NOTICE/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.

### SIGNATURES:

**SIGN  
HERE**

Signed at City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_

**Proposed Insured** \_\_\_\_\_

**SIGN  
HERE**

Signed at City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_

**Proposed Owner** (if other than Proposed Insured) \_\_\_\_\_



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