Royal Neighbors of America®

Application for Simplified Issue Individual Whole Life Insurance

INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠

230 16th St., Rock Island, IL 61201
(800) 627-4762 • www.royalneighbors.org

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Toll-free (800) 627-4762
A Fraternal Benefit Society

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❑ 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 _____

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 _____ ID Number _____ Percent _____
Please print

Agent Signature_____ Date _____
Agent Name _____ ID Number _____ Percent _____
Please print

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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.

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Supplemental Questionnaire for Individual Life Insurance

SECTION 1 – PROPOSED INSURED

This is a supplement to the application for life insurance for:

Proposed Insured Name: _____

❑ Simplified Issue Whole Life ❑ Single Premium Whole Life ❑ Jet Whole Life ❑ Jet Term Life

Date of Application for Life Insurance: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City, State, ZIP: _____

SECTION 2 – PROPOSED INSURED MEDICAL INFORMATION

1. In the past 30 days, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for COVID-19 (the SARS Co-V-2 virus)? ❑ YES ❑ NO

2. In the past 30 days, has a member of the medical profession administered a test on you for COVID-19, for which the results have not been received, or recommended that you be tested for COVID-19 (the SARS Co-V-2 virus)? ❑ YES ❑ NO

3. In the past 30 days, have you been advised by a medical professional to self-quarantine? ❑ YES ❑ NO

4. In the past 30 days, have you been treated, examined or advised by a member of the medical profession, whether in person, by phone or by other electronic means, for fatigue, fever, cough, or shortness of breath? ❑ YES ❑ NO

NOTICE

Only for products offering Graded Death Benefits, the following language is stricken from the application:
"If question 8 and 9 are answered YES, only Graded Death Benefit is available."

AGREEMENT / ACKNOWLEDGMENT

This Supplemental Questionnaire is made part of my application for life insurance. I have read this Supplemental Questionnaire, and to the best of my knowledge and belief, all answers are true and correct. I understand and agree that (1) any insurance shall be issued by Royal Neighbors of America is dependent on these answers being complete and correct; and (2) the answers given in the application, this Supplemental Questionnaire, and any other amendments to the application will be the basis of any insurance issued.

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

Signature of Proposed Insured: _____ Date: _____

Signature of Agent: _____ Date: _____