KSKJ LIFE
2439 GLENWOOD AVE.
JOLIET, IL 60435
1.800.843.5755
kskjlife.com

Illinois
Final Expense Cover Sheet

Agent Name (Please Print)_____ Agent #_____

Name of Insured (Please Print)

_____

❑ **Check Here if Point Of Sale Interview has been completed with ExamOne**

❑ **CHECK HERE IF CHECK IS INCLUDED WITH APP CHECK AMOUNT$_____**
Please make check or money order payable to " KSKJ Life"
****For applications written in Kansas, DO NOT collect money with the application***

If the method of payment is monthly bank draft, do you want the policy issued prior to the draft?

❑ YES ❑ NO

Please do not send in a bank deposit slip in place of a voided check for setting up bank drafts. Some banks use different routing numbers on the deposit slip and checks. If the wrong routing number is used, this can result in NSF drafts.

Other Comments:

If you would like to **FAX** in the application please fax to **1-815-483-2271.**
If you would like to **SCAN & EMAIL** in the application, please send to **applications@kskjlife.com**
***PLEASE DO NOT MAIL ORIGINAL COPY IF YOU FAX OR EMAIL THE APPLICATION.**

Application for Individual Life Insurance:

KSKJ LIFE A Fraternal Benefit Society

2439 Glenwood Ave, Joliet, Illinois 60435

800-843-5755 www.kskjlife.org

For Home Office Use Only

Premium Received

Amount: _____

Date: _____

Received By:_____

Policy Number :_____

Application Date: _____

Effective Date:_____

Are you a current member of KSKJ Life? NO_____ YES____ if "YES" , Lodge #_____

PROPOSED INSURED

Last_____ First_____ MI_____ Maiden_____

Date of Birth ____/_____/_____ Phone Number (____)_____-_____ Cell Number(____)_____-_____

S.S.#_____ Male_____ Female_____ Annual Income$_____ Occupation_____

Place of Birth_____ U.S. Citizen? Yes_____ No_____ Best Time to Call_____am _____pm

Street_____City_____State_____Zip_____

Email Address_____

Owner (if other than the Proposed Insured)

Last_____First_____MI___ Date of Birth _____/_____/_____

Phone Number ( )_____-_____ S.S. #_____Place of Birth_____ Male_____ Female____

Street_____City_____State_____Zip_____

Relationship to the Proposed Insured_____Email Address_____

The Payor is : _____Proposed Insured___Owner _____Other (if " Other," please provide the following information)

Last_____First_____MI___ Date of Birth _____/_____/_____

Phone Number ( )_____-_____ S.S. #_____Place of Birth_____ Male_____ Female____

Street_____City_____State_____Zip_____

Relationship to the Proposed Insured_____Email Address_____

Part A

1) Within the last 12 months has the Proposed Insured used tobacco products in any form? ____Yes____No
2) Does applicant have any existing life insurance or annuity contracts with KSKJ Life or any other company? ____Yes____No
3) Is the proposed insurance intended to replace or change any existing life insurance or annuity contract currently in force with KSKJ Life or any other company? (If "Yes", please submit the state-required forms.) ____Yes____No
4) Height_____ Weight_____
5) Change of Weight in Past Year _____lbs ❑ Gain ❑ Loss

Beneficiaries (with rights of revocation)

Name(s):	Relationship	Age	S.S.#	Address	Share%
Primary:					
Contingent:					

Part B1

If any response in this section is answered "Yes," the Proposed Insured is not eligible for coverage. Otherwise proceed to Part B2.

1) Is the Proposed Insured hospitalized, bedridden, residing in a nursing home or long term care facility, confined to a correctional facility, receiving hospice or home health care, confined to a wheelchair, received or been advised to have an organ transplant, or does the proposed insured require assistance with activities of daily living such as taking medications, bathing, dressing, eating, toileting, or moving around the house? ____Yes ____No

2) Has the Proposed Insured been medically treated or diagnosed by a licensed member of the medical profession or taken medication for:

a) Alzheimer's, dementia, mental retardation, Lou Gehrig's (ALS) disease, Huntington's disease, Downs syndrome, spina bifida not surgically corrected, cystic fibrosis, cerebral palsy or any terminal (i.e., death expecting to result within 1 year) medical condition? ____Yes ____No

b) Has the Proposed Insured ever Tested positive for the antibodies to the AIDS (HIV) virus or by a licensed member of the medical profession, been medically diagnosed with or received treatment for HIV, acquired immune deficiency syndrome (AIDS) or AIDS -related complex (ARC)? ____Yes ____No

c) Has the Proposed Insured ever been in a diabetic coma, insulin shock, had or been advised to have an amputation due to disease or disorder, or other than for pregnancy, taken insulin shots prior to age 30? ____Yes ____No

3) Within the past **2 years** has the Proposed Insured:

a) By a licensed member of the medical profession, been diagnosed with, been treated for, or advised to receive a treatment for internal cancer, melanoma, leukemia, multiple myeloma, or lymphoma (including Hodgkin's disease)? ____Yes ____No

b) By a licensed member of the medical profession, been advised to have surgery, hospitalization or a diagnostic test which has not yet been started, completed, or for which results are not known? ____Yes ____No

c) By a licensed member of the medical profession,been diagnosed with, been treated for, or advised to receive treatment for cirrhosis, congestive heart failure, cardiomyopathy, kidney failure, liver failure, muscular dystrophy, psychotic disorder or schizophrenia, or used or been advised to use oxygen to assist in breathing due to disease. ____Yes ____No

d) Been arrested 2 or more times for driving under the influence or had your drivers license suspended? ____Yes ____No

4) In the past five years has the Proposed Insured been convicted of a felony or are you currently serving a term of parole or probation assigned by the court? ____Yes ____No

Part B2

- If all responses in Part B2 are answered "No," proceed to Part B3.
- If one response in Part B2 is answered "Yes", the Proposed Insured may be eligible for Modified Final Expense. Proceed to Part C1. ***Circle the condition(s) to which each "Yes" answer, if any, applies.***
- If two or more responses in Part B2 are answered "Yes," the Proposed Insured is not eligible for coverage.
- In Part B2, all diagnosis, treatment or advise must have been given by a licensed member of the medical profession.

5) Within the past **4 years** has the Proposed Insured been diagnosed with or advised that you still have internal cancer, or received or advised to receive chemotherapy or radiation for internal cancer (other than the basal cell carcinoma)? ____Yes ____No

6) Within the past **18 months** has the Proposed Insured:

a) Used illegal drugs or been diagnosed with, been treated for, or advised to receive treatment for alcohol abuse, drug abuse, organic brain disease or sickle cell anemia? ____Yes ____No

b) Experienced more than 12 seizures or been diagnosed with, been treated for, or advised to receive treatment for hepatitis B or C or other liver disease? ____Yes ____No

c) By a licensed member of the medical profession, been diagnosed with, been treated for, or advised to receive treatment for heart attack, stroke (CVA), transient ischemic attack (TIA), aneurysm, angina, had or been advised to have heart surgery of any kind, including bypass surgery, angioplasty, stent implant or pacemaker implant, kidney dialysis or had a procedure to improve circulation? ____Yes ____No

Part B3

- If all responses in Part B3 are answered "No," the Proposed Insured may be eligible for Select Final Expense.
- If one response in Part B3 is answered "Yes," the Proposed Insured may be eligible for Standard Final Expense.
  Circle the condition(s) to which each "Yes" answer, if any, applies.
- If two or more responses in Part B3 are answered "Yes," the Proposed Insured is eligible for Modified Final Expense.
- In Part B3, all diagnosis, treatment or advise must have been given by a licensed member of the medical profession.

7) Within the past **3 years** has the Proposed Insured:

a) Experienced or been treated by a licensed member of the medical profession, for heart attack, angina (chest pain), stroke (CVA), transient ischemic attack (TIA), aneurysm, vascular, circulatory or blood disorder, had or been advised to have heart surgery of any kind, including bypass, angioplasty, stent implant, or pacemaker implant or atrial fibrillation. ____Yes ____No

b) Taken insulin shots or by a licensed member of the mdical profession,been diagnosed with, treated for, or advised to receive treatment for chronic pancreatitis, hepatitis B or C or other liver disease, or experienced more than 12 seizures. ____Yes ____No

c) Used illegal drugs or by a licensed member of the medical profession, been diagnosed with, been treated for, or been advised to receive treatment for alcohol or drug abuse? ____Yes ____No

8) Within the past **4 years** has the Proposed Insured, by a licensed member of the medical profession, been diagnosed with, been treated for, or been advised to receive treatment for kidney disease, not including kidney stones? ____Yes ____No

9) By a licensed member of the medical profession, has the Proposed Insured **ever** been diagnosed with, been treated for, or been advised to receive treatment for Parkinson's disease, systemic lupus, multiple sclerosis, chronic obstructive pulmonary disease (COPD), including emphysema, chronic asthma other than rare inhaler use, black lung or other chronic respiratory disease? ____Yes ____No

PHYSICIAN INFORMATION

Please complete by providing the following information:

Name :

Address :

Phone :

Current Medications (Last 4 Years)

Medication	Dosages	Reason for Taking

Please complete the following:

Part C1- Plan Tier, Face Amount & Payment Method

Plan Tier Applying For: Tier 1 (Select)_____ Tier 2 (Standard) _____Tier 3 (Modified)_____

Face Amount: $ _____(Min $5,000 ; Max $25,000)

Payment Method:

Modal Premium included or authorized with this application $_____

Payment Method: ____Annual _____Semi-Annual ____ Quarterly ____ Monthly Bank Draft

**If Bank Draft, Please Submit "Pre-Authorized Bank Draft Withdrawal Form"*

** Annual, Semi-Annual, or Quarterly - A check MUST be submitted with the application for the initial premium*

AGREEMENT-AUTHORIZATION

AGREEMENT - The application includes the Application –and all approved supplemental forms or amendments KSKJ Life, American Slovenian Catholic Union specifically designates as parts of the application by attaching copies of them to the policy delivered to the Owner.

I (WE): **REPRESENT** that, to the best of my (our) knowledge and belief, all statements included herein are true and complete; the insurance being applied for is suitable for the Owner's insurance needs; **AGREE** this application will be the basis for and a part of any contract of life insurance issued; and, **UNDERSTAND** that no agent or person other than our executive officers may, in writing: change, modify or waive any of the printed statements herein; or, waive any of our rights or requirements.

I (WE) **AGREE** that:

1. I (we) will notify KSKJ Life if any statement or answer given in the application changes prior to policy delivery; and
2. Except as provided in the Conditional Receipt insurance will not begin unless all persons proposed for insurance are living and insurable as set forth in the application at the time a policy is delivered to the Owner and
3. The first modal premium is paid and
4. No information will be considered as having been given to KSKJ Life unless it is written in this Application.

Except as may be provided in a Conditional Receipt bearing the same date as this application and for the same amount as shown on page 3 of this application, I (We) AGREE that no life insurance will take effect until: this application is approved at the KSKJ Life Home Office; a contract of life insurance is issued; and, the full first premium for the contract is paid. All such conditions must be met while the health and other factors affecting the insurability of the Proposed Insured(s) remain as described in this application.

AUTHORIZATION - This authorization complies with the HIPAA Privacy Rules

_____ _____-____-_____ _____

Name of Proposed Insured (please print) Social Security Number Date of Birth

_____

Address

_____ (_____)_____

City, State Zip Phone Number

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 5 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to KSKJ Life, American Slovenian Catholic Union and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes for specific purposes listed below. I also authorize any Pharmacy or Pharmacy Benefit Manager; Consumer Reporting Agency; Employer; Institution; Organization; or, Person; and, the MIB, Inc., who may have any records or information regarding me and, if so indicated below, my minor children, to provide such records or information to: KSKJ Life; its reinsurer; the MIB, or its legal representative. KSKJ Life may, at its discretion, obtain an investigative consumer report.

The undersigned understands that any records or information obtained will: be used to determine eligibility for insurance or benefits; and, be treated as confidential. However, KSKJ Life or its reinsurer may release any such records or information to: the MIB; other insurers to whom you may apply for insurance or submit a claim; or, as may be lawfully required.

Specific description of health information to be used or disclosed: _____
(e.g. if not specifically limited or restricted, the types of information to be used or disclosed may include medical, psychiatric, or psychological records, records of evaluation and treatment for alcohol or drug abuse, records and results of HTLV-III, HIV , or AIDS testing, etc.)
Approximate dates of treatment: _____
Purpose of the use or disclosure: _____
Purpose or organizations using or disclosing the information: KSKJ Life, American Slovenian Catholic Union
Persons or organizations receiving the information:_____

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. This protected health information is to be used to administer enrollment

determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with KSKJ Life. This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to KSKJ Life at 2439 Glenwood Ave., Joliet, IL 60435-5490, Attention: Underwriting Dept. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that KSKJ Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, KSKJ Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

This Authorization includes the minor children of the Proposed Insured: ____Yes. _____No.

KSKJ LIFE IS LICENSED TO DO BUSINESS IN THE STATE OF ILLINOIS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN THE ILLINOIS LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOWN AS THE GUARANTY ASSOCIATION). THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY.

Signed at_____ _____
City/State Date

_____ _____
Proposed Insured Signature Proposed Insured Printed

_____ _____
Owner Signature (if other than Proposed Insured) Owner Printed (if other than Proposed Insured)

_____ _____
Adult Applicant Signature(Parent/Legal Guardian) and/or Member Applicant ***(Applicable in Pennsylvania Only)*** Adult Applicant Printed(Parent/Legal Guardian) and/or Member Applicant ***(Applicable in Pennsylvania Only)***

_____ _____
Agent Signature and Agent No. Agent Printed

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.

AGENT'S REPORT

Proposed Insured:_____Application Dated:_____

1. To the best of your knowledge and belief will the insurance applied for replace or change any existing insurance or annuity?
❑ Yes ❑ No; comply with any statutory replacement requirements

2. Has the surname of the Proposed Insured changed in the last 10 years? ❑ Yes ❑ No; former surname:_____
_____

3. Does the Proposed Insured have any obvious illness, deformity or incapacity not specified in the application? ❑ Yes❑ No;
Explain:_____

4. Did you ask each question in the application exactly as stated and record the answer exactly as given? ❑ Yes. ❑ No;
Explain:_____

5. Are you aware of any information, not disclosed in the application, which may have a bearing on the issue of the insurance applied for?
❑ Yes ❑ No; details: _____

6. To the best of your knowledge and belief, is the plan and amount of insurance applied for suitable for the Proposed Insured?
❑ Yes ❑ No details:_____

7. Was a conditional receipt given to the Proposed Insured? ❑ Yes. ❑ No.

8. If not already a member, is the Proposed Insured a baptized Christian or is the Proposed Insured a spouse of a KSKJ Life member in good standing? ❑ Yes. ❑ No.

9. Photographic evidence used for verification of the identity of the Proposed Insured:

❑ Driver's License ❑ Passport ❑ Other_____

Remarks:_____
_____

_____	_____	_____	_____
Licensed Agent Signature	Agent Number	% Commission Split, if applicable	Date
_____	_____	_____	_____
Licensed Agent Signature	Agent Number	% Commission Split, if applicable	Date

Conditional Receipt
KSKJ Life, AMERICAN SLOVENIAN CATHOLIC UNION
2439 Glenwood Avenue, Joliet, IL 60435

THIS RECEIPT DOES NOT PROVIDE INSURANCE UNTIL ITS CONDITIONS ARE MET

Received from: _____ in connection with an application for life insurance.

On the life of: _____ the sum of: $ _____

Date: _____ Agent: _____

The insurance applied for will be effective on the issue date of the certificate

Provided, the following conditions are met, exactly:

1. The persons proposed for insurance are found to be standard risks for the amount and plan applied for in accordance with our underwriting rules then in effect;
2. The amount paid is sufficient to pay the first mode premium for the amount and plan applied for including any riders; and
3. The payment received is good and collectible.

The maximum amount of insurance which may become effective under this Conditional Receipt may not exceed $25,000. Such maximum amount shall include:

1. Any accidental death benefits applied for; and
2. Any other pending application for the Proposed Insured.

There will be no conditional insurance coverage and KSKJ Life's liability will be limited to returning any premium submitted to KSKJ Life with this Receipt if any of the following occurs:

A. One or more of the receipts conditions have not been met exactly
B. The Proposed Insured dies by suicide

Please contact us if you do not, within 60 days from the date of this receipt, receive: the life insurance contract applied for; or, a return of the amount paid. Please include: the name of the agent; and, the date and amount paid.

Do not pay in cash. All remittances must be payable to KSKJ Life, American Slovenian Catholic Union. Do not make payable to the agent or leave the payee blank.

NOTICEOF INFORMATION PRACTICES
KSKJ Life, AMERICAN SLOVENIAN CATHOLIC UNION

CONSUMER REPORT

This notice is to inform you that KSKJ Life, American Slovenian Catholic Union may obtain an investigative consumer report, as you have authorized. If obtained, the report will include information obtained through personal interviews with third parties, such as: financial sources; business associates; family members; friends; neighbors; or, others with whom you are acquainted. The report may include information as to your: character; general reputation; personal characteristics; and, mode of living. Within a reasonable period of time, you may, in writing, request additional, detailed, information regarding the nature and scope of any such report.

MIB, Inc.

Information regarding your insurability will be treated as confidential. I authorize KSKJ Life or its reinsurer to make a brief report of my personal health information to MIB, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member for life or health insurance coverage, or if a claim for benefits is submitted to such member, the MIB will, upon request, supply such member with the information it may have in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the MIB file information, you may contact the MIB and seek a correction in accordance with procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is: MIB Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734; telephone: (866) 692-6901. The KSKJ Life or its reinsurer may also release file information to other insurers to whom you may apply for life or health insurance; or, a claim may be submitted.

Fraud Warning Notices are included below. When the application is written in one of the listed states, the Notice for that state must, by law, be detached and given to the Applicant.

ARIZONA - FRAUD WARNING: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or commission, money or benefit is guilty of a class 2 misdemeanor.

COLORADO – FRAUD WARNING. It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or insurance agent who knowingly provides false, incomplete, or misleading information for the purpose of defrauding or attempting to defraud a policy holder or claimant with regard to an insurance settlement shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA – FRAUD WARNING. IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION, MATERIALLY RELATED TO A CLAIM, WAS PROVIDED BY AN APPLICANT.

OHIO – FRAUD WARNING. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA – FRAUD WARNING. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any factual material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PREAUTHORIZED BANK DRAFT WITHDRAWAL

I authorize KSKJ Life to draft specified premiums from the account listed below. I understand the draft will occur on the date I select in Section A. If I select no date, the debit will occur upon approval.

Insured Name

_____

Section A—Draft Date and Banking Information

Please indicate your preferred draft date *(1st—28th):*

Month_____ Date _____

Dates not available - 29th 30th 31st

New applications only:
Would you like the initial premium to be drafted upon approval? ☐ Yes ☐ No

Payor Name_____

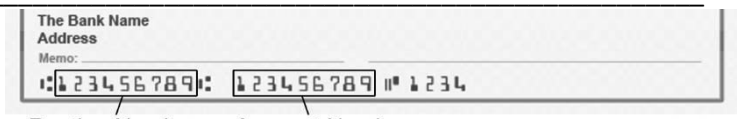
Bank Name_____

Bank Address_____

Routing # ___ ___ ___ ___ ___ ___ ___ ___ ___

Account # _____

☐ Checking ☐ Savings



Please do not send in a bank deposit slip in place of a voided check for setting up bank drafts. Some banks use different routing numbers on the deposit slip and checks. If the wrong routing number is used, this can result in NSF drafts.

Section B—Preauthorized Bank Draft Withdrawal Terms and Conditions

It is agreed that:

1. KSKJ Life debits your account monthly on the date you specify above. You will not receive a premium notice.
2. KSKJ Life may immediately terminate the Preauthorized Bank Draft Withdrawal agreement if any check is not paid upon presentation.
3. The Preauthorized Bank Draft Withdrawal's use shall in no way alter or amend policy provisions with respect to termination.
4. **Should your preferred draft date fall on a holiday or weekend, the funds will be withdrawn on the next business day.**

Section C—Signatures

By signing below, the account holder(s) acknowledge they have received, read, and agreed to the Preauthorized Bank Draft Withdrawal agreement's terms and conditions. Signatures should appear the same as on bank records.

_____ _____

Print Authorized Account Holder's Name | Print Additional Authorized Account Holder Name(s)

_____ _____

Authorized Account Holder's Signature Date | Additional Authorized Account Holder Signature(s) Date

Please attach a copy of a voided check—REQUIRED

HOME OFFICE USE ONLY

Certificate # _____ Premium Amount $_____

☐ Initial Premium ☐ New Bank Draft ☐ Change:_____Date _____Bank

Notes:_____