

**Use for Age
0 thru 15
ONLY**

POLISH NATIONAL UNION of AMERICA

referred to as the PNU - A Fraternal Benefit Society

[1002 Pittston Avenue Scranton, Pa 18505]

[1-800-724-6352 or 570-344-1513]

JUVENILE INSURANCE APPLICATION

**Use for Age
0 thru 15
ONLY**

1. Full name of Proposed Insured.

12. Plan of insurance _____

2. Address of Proposed Insured (include Zip + 4)

Amount of insurance \$

13. Premium payment frequency:

Annual Semiannual Quarterly Monthly
 Single Payment Other

3. Date of Birth: _____ Age: _____
Place of Birth: _____
Gender: Male Female

14. Dividend options:

Paid-up additions Cash

4. Social Security No.

15. Beneficiary or beneficiaries, with right of revocation, to whom proceeds shall be payable in equal shares in the event of death.

5. Telephone No. (____) _____
E-mail _____

Primary beneficiaries Relationship to insured

6. **Applicant (if other than Proposed Insured)**

Name: _____
Relationship: _____
Social Security No. _____
Address: _____

Contingent beneficiaries Relationship to insured

7. Mailing and Billing information

Mail Bill to Applicant Proposed Insured
Mail Official Publication to
 Applicant's address
 Proposed Insured's address

15a. Secondary addressee designated for the purpose of notification of a past due premium payment and possible lapse in coverage.

Name: _____
Address: _____

8. Has the Proposed Insured ever been declined, postponed or rated up for life insurance?
 Yes No

16. Provide any additional details to questions on page 1.

9. Is any application for any other life insurance on the life of the Proposed Insured now pending or contemplated? Yes No

17. State any special requests here.

10. Life insurance and annuities in force on Proposed Insured

Company	Year Issued	Plan	Amount

Fraud Warning

Any Person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

11. Will insurance being applied for replace or change any existing insurance coverage with the PNU or any other company?
 Yes No

Home Office Use Only

Certificate No.	Branch No.	Date Admitted	First Dues Payment Due	Date Received _____	Date of Processing _____
				Second Date Received _____	Second Date of Processing _____
				Medical Director Approval (when required) _____	Date _____
				Medical Director Check one: Standard <input type="checkbox"/> Sub Standard <input type="checkbox"/> _____	Reject <input type="checkbox"/>
				Approved for issue _____	Date _____

Questions 18 thru 27 apply to the Proposed Insured only.

18. What is the Proposed Insured's height? _____ feet _____ inches 19. What is the Proposed Insured's weight? _____ pounds	
20. If less than 1 year old, was Proposed Insured premature?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. To the best of your knowledge and belief has the Proposed Insured:	
a. any birth injury or do you know of any congenital or hereditary abnormality, disease, or trait which may affect the Proposed Insured's future health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. consulted with or been treated by a physician or other practitioner during the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Has the Proposed Insured been tested positive for exposure to HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Who is the usual medical attendant (family doctor or pediatrician) for the Proposed Insured? Please give full name and address . _____ _____ _____	
24. What is the date Proposed Insured last consulted or was examined by the usual medical attendant? _____	
25. What is the reason for last consultation or examination by the usual medical attendant? 	

Family Record

26. Full Name	Age	If Living, State of Health	Age at Death	If Deceased, Cause of Death
Father				
Mother				
Other children in family:				

27. Does Proposed Insured live with applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "No" with whom does the Proposed Insured live? _____ b. If "No" what is their relationship to the Proposed Insured? _____ c. If "No" provide complete address of relation named in 27 a. _____	

28. Details and additional information related to questions 18 thru 27:

AGREEMENT

I understand that all of my statements and answers shall be part of the contract of insurance when and if one is issued. I declare that all such statements and answers are, to the best of my knowledge and belief, true and complete.

I understand that no contract of insurance will be in effect until it is issued and delivered by the PNU during the Proposed Insured's lifetime; the Proposed Insured must be in the same state of health as when the application was signed; and the first premium must have been paid.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

This Authorization is designed to comply with the HIPPA Privacy Rule

I, the Proposed Insured's parent or legal guardian, hereby authorize any health plan, health care provider or health care clearinghouse, insurer, employer, or government agency that has provided payment, treatment or services to the Proposed Insured, to release to the persons or entities identified in Paragraph Number 1 below, information it has about the Proposed Insured's physical or mental health, financial position or educational achievement. Paragraph Number 2 below describes the class of persons or entities hereby authorized to release personal health information about the Proposed Insured. These persons or entities may disclose the information described in Paragraph Number 3 below.

1. The records and information will be disclosed to **The Polish National Union of America**, 1002 Pittston Avenue, Scranton, PA 18505 and their contractors, employees, representatives, affiliates and assigns as necessary to fulfill the purpose of this disclosure.
2. **Persons or entities hereby authorized to disclose personal health information about the Proposed Insured:** Any health plan, physician, surgeon, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit manager, medical facility or medically related facility, insurance company, workers compensation insurer, reinsurance company, insurance support organization (such as the Medical Information Bureau, Inc. (MIB)), or other health care provider, the Veterans Administration, the Social Security Administration, a consumer reporting agency, financial institution, educational institution and employer.
3. **Description of the information that may be disclosed:** This authorization specifically includes the release of the Proposed Insured's entire medical record and any other protected health information concerning the Proposed Insured including without limitation office notes, including those that describe a diagnosis, prognosis or response to treatment; results of all diagnostic tests; surgical notes; notes describing treatments provided, prescribed or recommended; history of prescriptions for pharmaceuticals; and all other information in your custody or control about any medical care or treatment provided to me. This authorization specifically includes information concerning the diagnosis or treatment of sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco. Any financial, employment or personal information requested for insurance purposes may also be disclosed.

The purpose of this disclosure is an application for life insurance coverage or to evaluate a claim for benefits on behalf of the Proposed Insured.

The **Polish National Union of America** may re-disclose information to reinsurance companies, to MIB, or their representatives, or to others who perform business or legal services related to the application or the policy or claim thereunder; in which case it may not be protected under federal privacy rules. Information will not be released to anyone else unless required or permitted by law or unless further authorized.

- This Authorization is good, as needed, for 30 months from the date signed or while a claim is open, if longer.
- I agree that a photocopy or facsimile of this authorization may be used the same as the original.
- I acknowledge that I have read this Authorization and received a copy of it.
- I understand that I may revoke this Authorization by sending written notice to the Polish National Union of America. Actions taken in reliance on this Authorization will not be affected, but no further actions will be taken in reliance on this Authorization after revocation is received by the Polish National Union of America. Revocation of this Authorization may result in the refusal to pay benefits under a policy that has been issued.

Signature of Applicant _____ Date _____

Signature of Proposed Insured's Parent or Legal Guardian _____ Date _____

DECLARATION OF AGENT

Is the insurance applied for intended to replace any existing insurance or annuity policies now in force? Yes No

Agent's State License No. _____ State Licensed in _____ Telephone No. _____ Branch No. _____

Agent's name(print) _____ Signature _____ Date _____

Organizer's name(print) _____ Signature _____ Date _____

POLISH NATIONAL UNION of AMERICA

Medical Examination Report

Must be completed by a licensed medical professional when required.

1. Height ft. in.	Did you measure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Weight lbs.	Did you weigh?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Pulse seated _____	Is pulse irregular?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "yes" describe and where applicable give the number of irregularities before and after exercise sufficient to increase pulse rate to 100 or more.		
4. Blood Pressure: Please record all readings. With Hypertension or if first reading is over 135 systolic or 85 diastolic take two additional readings. First Reading: Systolic _____ Diastolic _____ Second Reading: Systolic _____ Diastolic _____		
a. Is diastolic at disappearance of all sound?		<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is diastolic at change of sound?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you find any evidence of past or present disease: Provide Details to "Yes" answers		
a. of the heart and blood vessels? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
1. Is there a murmur? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is there any hypertrophy? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is there any arteriosclerosis? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
b. of the lungs? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
c. of any of the abdominal organs? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
d. of the skin, breasts, ears, middle ears, eyes, throat?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is there any enlargement of the Thyroid? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Is it symmetrical, asymmetrical, nodular, or diffuse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are the lymph nodes enlarged?		<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is there a hernia? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Was it ever strangulated?		<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is there any evidence of varicose veins or ulcers? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Do they extend above the knee?		<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is Proposed Insured lame, maimed, or deformed?		<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Does the Proposed Insured's appearance indicate good health?		<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Were the circumstances under which you completed examination satisfactory?		<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are you in any way related to the Proposed Insured or agent? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "Yes" to which one are you related and how?		
14. Are you aware of anything about the health, habits, environment, or mode of life of the Proposed Insured which might unfavorably affect his insurability? _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Do you have knowledge whether the Proposed Insured has been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?		<input type="checkbox"/> Yes <input type="checkbox"/> No

URINALYSIS

Specific Gravity?	Reaction?
Albumin?	Test Used?
Sugar?	Test Used?
Are you satisfied that the specimen is the Proposed Insured's?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

Examiner's Statement

I have carefully examined _____ this _____ day of _____, 20____

Examination was made in private at my office residence of Proposed Insured place of business of Proposed Insured.

Signature of Examiner _____ Print name of Examiner _____ Examiner's address: street and number _____ city, state, zip code _____	<p>Fraud Warning</p> Any Person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
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