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.

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

3. Date of Birth: ________________ Age: ________________
   Place of Birth: ________________
   Gender: ☐ Male ☐ Female

4. Social Security No.

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

6. **Applicant (if other than Proposed Insured)**
   Name: ________________
   Relationship: ________________
   Social Security No. ________________
   Address: ________________

7. Mailing and Billing information
   Mail Bill to ☐ Applicant ☐ Proposed Insured
   Mail Official Publication to
   ☐ Applicant's address
   ☐ Proposed Insured's address

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

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

10. Life insurance and annuities in force on Proposed Insured

Company	Year Issued	Plan	Amount

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

12. Plan of insurance ________________

    Amount of insurance $

13. Premium payment frequency:
    ☐Annual ☐Semiannual ☐Quarterly ☐Monthly
    ☐Single Payment ☐Other

14. Dividend options:
    ☐ Paid-up additions ☐ Cash

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

Primary beneficiaries	Relationship to insured
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.	
.	
.	

Contingent beneficiaries	Relationship to insured
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.	
.	

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

17. State any special requests here.

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 fact material thereto commits a fradulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Home Office Use Only

Branch No.

Certificate 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 ☐ Sub Standard ☐________ Reject ☐

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? ☐Yes ☐ 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? ☐Yes ☐ No

b. consulted with or been treated by a physician or other practitioner during the past 5 years? ☐Yes ☐ No

22. Has the Proposed Insured ever been diagnosed by a licensed physician as having been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related-Complex (ARC), HIV or any other disease of the immune system? ☐Yes ☐ 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? ☐Yes ☐ 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 Human Immunodeficiency Virus (HIV), 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 there under; 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?	☐Yes ☐ No
2. Weight lbs. Did you weigh?	☐Yes ☐ No
3. Pulse seated _________________ Is pulse irregular? 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.	☐Yes ☐ No
4. Blood Pressure: Please record all readings. With Hypertension or if first reading is over 135 systolic or 85 daistolic take two additional readings. First Reading: Systolic _______________ Diastolic_________________ Second Reading: Systolic Diastolic	
a. Is diastolic at disappearance of all sound?	☐Yes ☐ No
b. Is diastolic at change of sound?	☐Yes ☐ No
5. Do you find any evidence of past or present disease: | **Provide Details to "Yes" answers**	
a. of the heart and blood vessels? ______________________________	☐Yes ☐ No
1. Is there a murmur? ______________________________	☐Yes ☐ No
2. Is there any hypertrophy? ______________________________	☐Yes ☐ No
3. Is there any arteriosclerosis? ______________________________	☐Yes ☐ No
b. of the lungs? ______________________________	☐Yes ☐ No
c. of any of the abdominal organs? ______________________________	☐Yes ☐ No
d. of the skin, breasts, ears, middle ears, eyes, throat?	☐Yes ☐ No
6. Is there any enlargement of the Thyroid? ______________________________	☐Yes ☐ No
a. Is it symmetrical, asymmetrical, nodular, or diffuse?	☐Yes ☐ No
7. Are the lymph nodes enlarged?	☐Yes ☐ No
8. Is there a hernia? ______________________________	☐Yes ☐ No
a. Was it ever strangulated?	☐Yes ☐ No
9. Is there any evidence of varicose veins or ulcers? ______________________________	☐Yes ☐ No
a. Do they extend above the knee?	☐Yes ☐ No
10. Is Proposed Insured lame, maimed, or deformed?	☐Yes ☐ No
11. Does the Proposed Insured's appearance indicate good health?	☐Yes ☐ No
12. Were the circumstances under which you completed examination satisfactory?	☐Yes ☐ No
13. Are you in any way related to the Proposed Insured or agent? ______________________________ a. If "Yes" to which one are you related and how?	☐Yes ☐ No
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? ______________________________	☐Yes ☐ No
15. Do you have knowledge of the Proposed Insured ever being diagnosed by a licensed physician as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), Aids-Related-Complex (ARC), HIV or any other disease of the immune system?	☐Yes ☐ No

URINALYSIS

Specific Gravity?	Reaction?
Albumin?	Test Used?
Sugar?	Test Used?
Are you satisfied that the specimen is the Proposed Insured's?	☐Yes ☐ No

Examiner's Statement

I have carefully examined ______________________________ this ________ day of ________, 20___

Exanination 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 ______________________________