Russian Brotherhood Organization of the U.S.A.

Philadelphia, Pennsylvania

A Fraternal Benefit Society

APPLICATION FOR INSURANCE

1. FULL NAME: First / Middle / Last

2. RESIDENCE ADDRESS: No., Street or RFD / Town, State / Zip Code

3. S.S. #

4. TELEPHONE NO.

5. BIRTHPLACE: (State or Country)

6. NATIONALITY:

7. RELIGION

8. DATE OF BIRTH: Mo.: Day: Year:

9. AGE NEAREST BIRTHDAY

10. MARITAL STATUS:

11. MALE OR FEMALE:

12. Is Proposed Insured now a member of the Russian Brotherhood Organization? YES ☐
If not, apply for membership. NO ☐

13. PLAN OF INSURANCE APPLIED FOR:
Plan ______________________, Initial Amount ______________
Premium Period ______________ Yrs. Other Benefits ______________
Premium Mode (Annually, Semi-Annually, Quarterly, Monthly ______________

14. PRIMARY BENEFICIARY: First / Middle Initial / Last / Relationship

15. CONTINGENT BENEFICIARY: First / Middle Initial / Last / Relationship

16. SPECIAL REQUESTS

17. a. OCCUPATION: ______________ d. YEARS EMPLOYED: ______________
b. EMPLOYER: ______________ e. ANNUAL INCOME: ______________
c. EMPLOYER'S ADDRESS: ______________ (No., Street or RFD / Town, State / Zip Code)

18. LIFE INSURANCE CURRENTLY IN-FORCE:

COMPANY	ISSUE YEAR	LIFE INSURANCE AMT.	ADB AMT.

	YES	NO
19. Is the insurance applied for intended to replace any existing insurance in-force? (If yes, give Company Name and Policy Number.)		
20. Has any application for insurance ever been declined, postponed or rated? (If yes, give details.)		
21. Has any other application been made for life insurance within the past 4 months? (If yes, give Company and amount.)		
22. Does the proposed insured now, or intend in the future, to be engaged as a pilot or crew member, or in skin or scuba or sky diving, racing or rodeo activities? (If yes, give details.)		

HEALTH QUESTIONS PERTAINING TO PROPOSED INSURED

23. Height: ____ Ft. ____ In. ____ Weight ________ lbs. ____ Has your weight changed in the past year? ____________
If "yes", give pounds gained or lost and reason in #27.

24. Has the Proposed Insured ever been treated for or ever had any known indication of: *(If answer to any item is "yes", give details in #27.)*	YES	NO
(a) Disorder of nose, throat, eyes or ears including impaired sight, speech or hearing?		
(b) Disorder of the nervous system, including epilepsy, fainting, convulsions, headaches, paralysis, mental disorder, nervousness or psychiatric treatment?		
(c) Disorder of lungs or respiratory system, including asthma, bronchitis, emphysema, tuberculosis, shortness of breath, persistent cough or hoarseness?		
(d) Chest pain, heart attack, high blood pressure, heart murmur, irregular heartbeat, phlebitis, thrombosis, varicose veins, anemia or other disorder of the heart, blood vessels or blood?		
(e) Ulcer, hernia, colitis, diverticulitis, rectal disorder, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder?		
(f) Sugar, albumin, pus or blood in the urine, stone or other disorder of the kidney or bladder?		
(g) Diabetis, goiter or other disorder of the thyroid, glandular or endocrine system?		
(h) Rheumatism, arthritis, neuritis, sciatica, gout or disorder of muscles or bones, including the spine, back or joints?		
(i) Deformity, lameness or amputation?		
(j) Cancer, tumor, cyst or disorder of the skin or lymph glands?		
(k) Disorder of the prostate, reproductive organs, menstruation, pregnancy or of the breasts?		
(l) Except as legally prescribed by a physician, used: cocaine, barbiturates, heroin, or any narcotic drug?		
(m) Sought or received advice for, or treatment of, or been arrested for the use of alcohol, marijuana or drugs?		
(n) Is Proposed Insured now pregnant? How many months?		
25. Is Proposed Insured taking, or has taken in the past two years, treratment or medication?		
26. During the past five years has Proposed Insured had medical or surgical advice or treatment not mentioned above, including X-ray, Electriocardiogram or other test?		

27. Give details here for item answered "YES" in questions 23, 24, 25, or 26.

QUESTION NO.	QUESTION	TREATMENT TYPE OF	TREATMENT DATES OF	DEGREE OF RECOVERY	LENGTH OF DISABILITY	ATTENDING PHYSICIAN AND/OR HOSPITAL NAME	ATTENDING PHYSICIAN AND/OR HOSPITAL ADDRESS

QUESTIONS PERTAINING TO APPLICANT IF OTHER THAN PROPOSED INSURED

28. FULL NAME: (FIRST) (MIDDLE) (LAST)

29. RESIDENCE ADDRESS: (No., Street or RFD) (Town, State) (Zip Code)

30. BIRTHPLACE (State or Country)

31. DATE OF BIRTH: Mo. ______ Day ________ Yr. ____

32. a. OCCUPATION: ____________________ d. YEARS EMPLOYED: ____________
b. EMPLOYER: ____________________ e. ANNUAL INCOME: ____________
c. EMPLOYER'S ADDRESS: (No., Street or RFD) (Town, State) (Zip Code) ____________________

33. LIFE INSURANCE CURRENTLY IN-FORCE:	COMPANY	ISSUE YEAR	LIFE AMOUNT	ADB AMT.

Representation, Authorization, and Acknowledgement

I represent that the statements and answers given above are true and complete to the best of my knowledge and belief.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution, or person that has any records or knowledge of me or my health to give the Russian Brotherhood Organization of the U.S.A., or its reinsurers, any such information. I also authorize procurement of a Consumer Investigative Report. A copy of this authorization shall be as valid as the original.

INSURANCE COVERAGE WILL BEGIN ON THE ISSUE DATE SHOWN ON THE CERTIFICATE.

I acknowledge receipt of the NOTICE TO APPLICANT

Dated at: ______________________ Date: ______________________

Proposed Insured's Signature: ______________________

Adult Applicant's Signature: ______________________

Witness: ______________________ (Secretary)

Recommender______________________

NOTICE TO SECRETARY: Federal and state regulations require you to detach and deliver the notice below to applicant.

NOTICE TO APPLICANT

The underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and provide a mechanism by which each policyholder pays his fair share of the cost. In considering your application, information from various sources is considered, including your own statements, the results of your physical examination (if required) and any reports we receive from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. We, or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Agent's Certification

		YES	NO
1.	(a) Have you reviewed the entire application for corrections or omissions?	☐	☐
	(b) Have you personally seen all persons to be insured?	☐	☐
	(c) Do all proposed insureds appear to be in good health?	☐	☐
	(d) Do you have knowledge or reason to believe that replacement of existing insurance may be involved?	☐	☐
	(e) Have you given the proposed insured the attached (Fair Credit and M.I.B.) notices?	☐	☐

2. Did you arrange for a medical examination?_______ Name and address of Examiner ______________________

3. Special requests, remarks and instructions. ______________________

4. I certify that I delivered to the applicant the required OUTLINE OF COVERAGE provided by the insurance applied for. (Disregard if such Outline is not required by your insurance department.)

   I certify that I personally solicited this application and that I know nothing against the risk which is not fully set forth in this application.

Date ____________________ , 19______ Signature of Secretary ______________________

Recommender______________________________ Lodge # ______________

This notification must be delivered to the Proposed Insured.

THANK YOU FOR CONSIDERING OUR COMPANY AS YOUR INSURANCE CARRIER.

As part of our procedure for processing your application, a Consumer Investigative Report may be made whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted.

This report will include, as applicable, information as to your character, general reputation, personal characteristics and mode of living. Upon written request, a copy of the Consumer Investigative Report, if one is made, wil be made available to you.

RBO
Russian Brotherhood Organization of the U.S.A.
301 Oxford Valley Road
Suite 1602 B
Yardley, Pennsylvania 19067

SEE REVERSE SIDE FOR IMPORTANT NOTICE