

Russian Brotherhood Organization of the U.S.A.

1733 Spring Garden Street, Philadelphia, PA 19130-3915
215-563-2537 or 1-800-RBO-USA1 (800) 726-8721 FAX-(215) 563-8106
A FRATERNAL BENEFIT SOCIETY

APPLICATION FOR INSURANCE

Please print clearly.

1. Name in Full of Proposed Insured _____ Male Female

2. Applicant (if other than Proposed Insured) _____

3. Address _____

City _____ State _____ Zip Code _____

4. Social Security # _____ 5. Phone (Day) _____ (Evening) _____

6. Date of Birth _____ 7. Age Last Birthday _____

8. Place of Birth: City _____ County _____ State _____

9. Single Married Widow Divorced 10. Height _____ Weight _____

11. By whom employed? _____ Occupation _____

12. Plan of Insurance _____ 13. Face Amount \$ _____

14. Premium Mode: Annual Semi-Annual Quarterly Monthly Single Premium

15. Is the Proposed Insured a member of the Society? Yes No If not, please apply for membership.

16. Beneficiaries (List additional beneficiaries in REMARKS):

| <u>Primary Beneficiary</u> | <u>Relationship to Insured</u> | <u>Contingent Beneficiary</u> | <u>Relationship to Insured</u> |
|----------------------------|--------------------------------|-------------------------------|--------------------------------|
| 1. _____ | _____ | 1. _____ | _____ |
| 2. _____ | _____ | 2. _____ | _____ |
| 3. _____ | _____ | 3. _____ | _____ |

17. Name and Address of optional Secondary Addressee (for notification of a past due premium or possible lapse of coverage)

| 18. Family History | Age if Living | Health if Living | Age at Death | Year of Death | Cause of Death or if Living and Not In Good Health Give Nature of Ailment. | Duration of Last Illness |
|--------------------|---------------|------------------|--------------|---------------|--|--------------------------|
| Father | | | | | | |
| Mother | | | | | | |
| Brothers | | | | | | |
| Sisters | | | | | | |

19. List amounts of insurance and annuities now in force on the Proposed Insured and Applicant.

Company

Amount

NOTE: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

20. Will the insurance being applied for replace or change any existing life insurance or annuities in this or any other company?

Yes No If Yes, give details and name of companies in REMARKS below.

21. In the past 10 years, has the Proposed Insured been treated by a licensed member of the medical profession for:

- | | Yes | No | (If yes, circle each applicable item and explain in REMARKS below) |
|----|--------------------------|--------------------------|--|
| A. | <input type="checkbox"/> | <input type="checkbox"/> | Any disease or disorder of eyes, ears, nose or throat? |
| B. | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness, fainting, convulsions, head injury, chronic headaches, paralysis or stroke, or any disease of the brain or nervous system? |
| C. | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough, blood spitting, asthma, emphysema, tuberculosis or lung or respiratory disorder? |
| D. | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain, high blood pressure, heart attack, rheumatic fever, heart murmur, or other heart or blood vessel disorder? |
| E. | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, ulcer, colitis, diverticulitis, or other disorder of the stomach, intestines, liver, gall bladder, pancreas or spleen? |
| F. | <input type="checkbox"/> | <input type="checkbox"/> | Sugar, albumin, blood or pus in urine, venereal disease, stone or any other kidney, bladder, prostate or reproductive organ disorder? |
| G. | <input type="checkbox"/> | <input type="checkbox"/> | Allergies, anemia or other disorders of the blood? |
| H. | <input type="checkbox"/> | <input type="checkbox"/> | Neuralgia, neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones including the spine, back or joints? |
| I. | <input type="checkbox"/> | <input type="checkbox"/> | Disorder of the skin or lymph glands, cyst, tumor or cancer? |
| J. | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes, thyroid or other glandular disorder? |
| K. | <input type="checkbox"/> | <input type="checkbox"/> | Diagnosis by a licensed physician as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related-Complex (ARC), or any other disease of the immune system? |

22. Has the Proposed Insured:

- | | Yes | No | |
|----|--------------------------|--------------------------|---|
| L. | <input type="checkbox"/> | <input type="checkbox"/> | In the past 2 years, ever flown or plan to fly, as a pilot, student or crew? |
| M. | <input type="checkbox"/> | <input type="checkbox"/> | Regularly traveled or resided or have plans to travel or reside outside the USA? |
| N. | <input type="checkbox"/> | <input type="checkbox"/> | Ever been convicted of a felony? |
| O. | <input type="checkbox"/> | <input type="checkbox"/> | Had 2 or more motor vehicle violations in the past 3 years, ever been convicted of driving while intoxicated, or ever had license suspended or revoked? |
| P. | <input type="checkbox"/> | <input type="checkbox"/> | In the past 2 years, engaged in, or plan to engage in sky or scuba diving, hang-gliding, bungee jumping, rock climbing, or any form of motorized racing (automobile, snowmobile, motorcycle, boat or go-cart)? |
| Q. | <input type="checkbox"/> | <input type="checkbox"/> | In the past 5 years, received advice or treatment from a member of the medical profession for the use of alcohol or drugs, or been convicted of using, selling or possessing any narcotics, stimulant, sedative or hallucinogenic drug? |
| R. | <input type="checkbox"/> | <input type="checkbox"/> | Used tobacco or nicotine in any form in the last 12 months? |

Please provide explanations for all Yes answers in REMARKS below. Add an additional sheet of paper, if necessary.

REMARKS

PROPOSED INSURED/APPLICANT STATEMENT

I declare that the statement and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief. **I understand that coverage will not be effective until the first premium has been paid and the contract has been delivered.**

I authorize the RUSSIAN BROTHERHOOD ORGANIZATION OF THE USA, its agents, employees, reinsurers, and their representatives to obtain information about the Proposed Insured to evaluate this application and to verify information in this application. This information will include: (a) age; (b) medical history, condition and care; (c) physical and mental health; (d) occupation; and (e) other insurance. This authorization extends to information on the use of tobacco; the diagnosis or treatment of the AIDS virus (excluding HIV) and sexually transmitted diseases; and the diagnosis and treatment of mental illness. During the time this authorization is valid it extends to information required to determine eligibility for benefits under any policy issued as a result of this application.

I authorize any person, including any physician, health care professional, hospital, clinic, medical facility, government agency including the Veterans and Social Security Administrations, employer, or other insurance company, to release information about the Proposed Insured to the RUSSIAN BROTHERHOOD ORGANIZATION OF THE USA or its representatives on receipt of this authorization. This information should include medical history, physical and laboratory findings (special tests, X-rays, electrocardiograms, etc.) and conclusions regarding the Proposed Insured's health. This authorization specifically excludes psychotherapy notes. The information will be used to determine whether or not the Proposed Insured is an acceptable risk for life insurance. The RUSSIAN BROTHERHOOD ORGANIZATION OF THE USA or its representatives may release this information about the Proposed Insured to reinsurers or to another insurance company to whom the Proposed Insured has applied or to whom a claim has been made. No other release may be made except as allowed by law or as I further authorize.

This authorization is valid for 30 months from the date it is signed. A copy of this authorization is as valid as the original and will be provided on request. I may revoke this authorization at any time by writing to the RUSSIAN BROTHERHOOD ORGANIZATION OF THE USA.

Signature of Proposed Insured

Date Signed by Proposed Insured

Signature of Adult Applicant if Proposed Insured is under the age of 18

Date Signed by Adult Applicant

Signature of Member Applicant if Proposed Insured is not a member of the Society

Date Signed by Member Applicant

AGENT'S STATEMENT

Was this insurance applied for to replace or change any existing insurance or annuity contract? Yes No

If Yes, provide required disclosure notices to the Proposed Insured.

Signature of Agent

Date Signed by Agent