Russian Brotherhood Organization of the U.S.A.

A FRATERNAL BENEFIT SOCIETY

301 Oxford Valley Road Suite 1602B
Yardley, PA 19067
(215) 563-2537/ Fax: (215) 563-8106

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. Dividend Option: ☐ Cash ☐ Paid-Up Addition

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

17. Beneficiaries (List additional beneficiaries in REMARKS):

Primary Beneficiary	Relationship to Insured	Contingent Beneficiary	Relationship to Insured
1.		1.	
2.		2.	
3.		3.	

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

_____

19. 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						

20. List amounts of insurance and annuities now inforce on the Proposed Insured (and Applicant if Proposed Insured is less than age 14 ½). List company Names and Amount.

Company Amount

_____

_____

_____

21. 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.

22. 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.	☐	☐	Any disease or disorder of eyes, ears, nose or throat?
B.	☐	☐	Dizziness, fainting, convulsions, head injury, chronic headaches, paralysis or stroke, or any disease of the brain or nervous system?
C.	☐	☐	Chronic cough, blood spitting, asthma, emphysema, tuberculosis or lung or respiratory disorder?
D.	☐	☐	Chest pain, high blood pressure, heart attack, rheumatic fever, heart murmur, or other heart or blood vessel disorder?
E.	☐	☐	Hepatitis, ulcer, colitis, diverticulitis, or other disorder of the stomach, intestines, liver, gall bladder, pancreas or spleen?
F.	☐	☐	Sugar, albumin, blood or pus in urine, venereal disease, stone or any other kidney, bladder, prostate or reproductive organ disorder?
G.	☐	☐	Allergies, anemia or other disorders of the blood?
H.	☐	☐	Neuralgia, neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones including the spine, back or joints?
I.	☐	☐	Disorder of the skin or lymph glands, cyst, tumor or cancer?
J.	☐	☐	Diabetes, thyroid or other glandular disorder?

23. Has the Proposed Insured:

	Yes	No	
K.	☐	☐	Ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related-Complex (ARC)?
L.	☐	☐	In the past 2 years, ever flown or plan to fly, as a pilot, student or crew?
M.	☐	☐	Have plans to travel or reside outside the USA?
N.	☐	☐	Ever been convicted of a felony?
O.	☐	☐	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.	☐	☐	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.	☐	☐	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.	☐	☐	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 UNITED STATES OF AMERICA, 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 UNITED STATES OF AMERICA 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 UNITED STATES OF AMERICA 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 UNITED STATES OF AMERICA.

_____ _____

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