INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠
Royal Neighbors of America
230 16th Street
Rock Island, IL 61201
(800) 627-4762
A Fraternal Benefit Society

Mail Certificate to: ❑ Agent ❑ Owner

Application for Individual Single Premium Whole Life Insurance

PART 1

SECTION 1 – Proposed Insured

Name _____ Street _____
City _____ State _____ ZIP _____
Phone number (_____) _____ Identification:
DOB _____ ❑ U.S. driver's license ❑ Government issued ID
SSN/Tax ID _____ ID number _____
Marital status ❑S ❑M ❑W ❑D Sex ❑ M ❑ F ID issuer _____
State/Country of birth _____ Email address _____
Are you a U.S. citizen? ❑ Yes ❑ No If No, are you a legal U.S. resident (Green Card)? ❑ Yes ❑ No

SECTION 2 – Other Insurance

1. EXISTING or APPLIED FOR INSURANCE
Does the Proposed Insured have any existing life insurance (L) or annuity (A) contracts with this or any other company? ❑ Yes ❑ No
IF YES, complete and submit state replacement forms, if required, with this application.

2. REPLACEMENT
In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions), involving an annuity or other life insurance? ❑ Yes ❑ No
If Yes, complete and submit a replacement questionnaire **AND** any other state required replacement forms with this application.

SECTION 3 – Proposed Owner*

*** Complete if Proposed Owner is other than Proposed Insured**

Sex ❑ M ❑ F Relationship to Proposed Insured _____
Name _____ Email address _____
Street _____ Identification:
City _____ State _____ ZIP _____ ❑ U.S. driver's license ❑ Government issued ID
SSN/Tax ID _____ ID number _____
Phone number ( ) _____ DOB _____ ID issuer _____
Are you a U.S. citizen? ❑ Yes ❑ No If No, are you a legal U.S. resident (Green Card)? ❑ Yes ❑ No

SECTION 4 – Beneficiary*(ies)*

Multiple Beneficiaries will receive an equal percentage of proceeds per capita unless otherwise instructed.

☒ PRIMARY
Name _____
Street _____
City _____ State _____ ZIP _____
DOB _____ SSN/Tax ID _____
Relationship to Proposed Insured _____
Percent of proceeds _____%

❑ PRIMARY ❑ CONTINGENT
Name _____
Street _____
City _____ State _____ ZIP _____
DOB _____ SSN/Tax ID _____
Relationship to Proposed Insured _____
Percent of proceeds _____%

SECTION 5 – Information Regarding Insurance Applied for

1. ☒ SINGLE PREMIUM WHOLE LIFE

2. SINGLE PREMIUM –
❑ Cash with application .....$ _____
❑ Cash to be received before issue .....$ _____
❑ Funds from §1035 Exchange .....$ _____
(from existing life contract only)

3. ESTIMATED FACE AMOUNT ..... **$** _____

4. RIDERS
☒ Accelerated Death Benefit - Terminal Illness ***(to remove, strike through and Proposed Owner initial here _____.)***
❑ Accelerated Death Benefit - Chronic Illness
(Choosing this rider may affect eligibility for Gov't Programs)
❑ Accelerated Death Benefit - Critical Illness
(Choosing this rider may affect eligibility for HDP)

5. DIVIDEND OPTION
❑ Paid in cash
❑ Left on deposit to accumulate at interest

SECTION 6 – Financial Questions

Has the Proposed Insured or Proposed Owner:

1. Entered into any agreement or arrangement providing for the future sale of the insurance Certificate applied for in this application? ..... ❑ Yes ❑ No
2. Entered into any agreement or arrangement where someone else will pay some or all of the premium, or the Proposed Insured or Proposed Owner will receive financing or a loan, including forgivable loans, to pay some or all of the premium, costs or other expenses associated with this loan? ..... ❑ Yes ❑ No
3. Entered into any agreement either orally or in writing by which you are to receive any form of consideration in exchange for procuring the insurance Certificate applied for? ..... ❑ Yes ❑ No

Financial Information: (Please initial box if you do not want to disclose information)

Annual Gross Income ..... $ _____ ☐

Liquid assets (e.g. checking account, savings account, CDs) ..... $ _____ ☐

Source of Funds to Pay Single Premium (e.g. savings): _____

Available Funds:

Do you have sufficient cash or other liquid funds for living expenses and emergencies, such as unexpected medical expenses, in addition to the money you plan to use to purchase this life insurance. ❑ Yes ❑ No

PART 2

SECTION 1 – Proposed Insured Physician Information

Provide name and address of primary physician, practitioner, or health care facility who can provide the most complete and up-to-date information concerning the present health of the Proposed Insured:

Physician name _____ Name of practice/clinic _____

Street _____ City, State, ZIP _____

Phone number ( ) _____ Fax number ( ) _____

SECTION 2 – Proposed Insured Medical Information

1. Height (ft. and in.) _____ Weight (lbs.) _____
2. In the past 12 months has the Proposed Insured used any product containing tobacco and/or nicotine? ..... ❑ Yes ❑ No
3. In the past 12 months has the Proposed Insured:
   a. been recommended or had any surgery or diagnostic testing by a medical professional which has not been completed or for which the results have not been received? ..... ❑ Yes ❑ No
   b. been confined to a wheelchair, used oxygen to assist breathing, or hospitalized or in a medical or a long term care facility? .. ❑ Yes ❑ No
4. Within the past 5-years has a member of the medical profession diagnosed the Proposed Insured as having, treated, or advised to seek treatment for, or prescribed medication for:
   a. cancer, diabetes, stroke or any disease or disorder of the heart, circulatory, respiratory, kidney, liver, brain or nervous system? ..... ❑ Yes ❑ No
   b. Brain, mental or emotional nervous disorder; dementia, Alzheimer's, eye disorder; epilepsy, seizures, paralysis; depression; anxiety; or any other disease or disorder of the nervous system? ..... ❑ Yes ❑ No
   c. Arthritis; loss of limb, or deformity; disorder of bone, joint, muscle, back, or spine; lupus, connective tissue disorder; or any other disorder of the musculoskeletal system? ..... ❑ Yes ❑ No
5. Within the past 5-years has the Proposed Insured:
   a. used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician? ..... ❑ Yes ❑ No
   b. received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ..... ❑ Yes ❑ No
6. Has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ..... ❑ Yes ❑ No

For questions 3 through 6, please circle the applicable item(s) in each question above and provide details to all YES answers below.

Question #	Name of Physician/Address	Illness Date/Duration	Diagnosis/Medications/Treatments

Additional Information:

Corrections and Amendments (For Home Office Use Only)

Agreement/Acknowledgement

Agreement/Disclosure: I have read this application for life insurance including any amendments and supplements and, to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any certificate issued and will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors of America (Royal Neighbors), become part of the new Certificate.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in this application and amendment(s), paramedical/medical exam, and any supplement(s).
- Only authorized officers of Royal Neighbors may: a) make or change any contract of insurance; b) make a binding promise about insurance; or c) change or waive any term of an application, receipt, or Certificate.
- Corrections, additions, or changes to this application may be made by Royal Neighbors. Any such changes will be shown under "Corrections and Amendments." Acceptance of a certificate issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
- If not a current member, I, the Proposed Insured, hereby apply to become a member of Royal Neighbors as indicated by my signature on page 4. As a member, I agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors was founded more than 120 years ago.
- **The type of insurance product I am purchasing has characteristics which generally require treatment as a Modified Endowment contract (MEC). I have received information regarding MEC's and understand that if the transaction now pending with respect to my life insurance Certificate becomes a MEC, it may result in future tax liability for me.**

Authorization

I, the Proposed Insured, hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical facility, insurance or reinsurance company, MIB, Inc., consumer reporting agency, division of motor vehicles, the veterans administration, or other government agency or department having information as to the diagnosis, treatment, or prognosis with respect to any physical or mental condition, or having any non-medical information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past 10 years, without restriction, to Royal Neighbors of America (Royal Neighbors), its agents, employees, or representatives. I further authorize Royal Neighbors, or its reinsurers, to make a brief report of my personal health information to MIB. This includes information on the treatment of alcohol, drug, and tobacco abuse, and psychiatric diagnosis and treatment. **In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, to give such information to any legal representative or agent employed by Royal Neighbors. I understand this authorization complies with the HIPAA Privacy Rule.**

I understand that the protected information is to be disclosed under this authorization so that Royal Neighbors may underwrite my application for life insurance, determine my eligibility for insurance, risk rating, or certificate issuance determinations, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have applied for with Royal Neighbors. Any protected information obtained will not be released and or reported by Royal Neighbors to any person or organization EXCEPT to other divisions and/or departments of Royal Neighbors, MIB, other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted, or other persons or organizations performing business or legal services in connection with my application, insurance certificate(s), or claim for benefits or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for 24 months or as permitted by applicable law in the state where the certificate is delivered or issued for delivery from the date signed if used in connection with an application for a life insurance certificate, an application for reinstatement of a life insurance certificate, or a request for change in certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative is entitled to receive a copy. I understand that this authorization may be revoked by me at any time in writing, and if I refuse to sign or if I subsequently revoke this authorization, Royal Neighbors may not be able to process this application, and if coverage has been issued, may not be able to process any benefit payments. I agree that Royal Neighbors shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation at its Home Office or to the extent that Royal Neighbors has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be re-disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Proposed Owner, certify that:
The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:
a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; **OR**
b) the IRS has notified me that I am not subject to backup withholding. *(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*
I am a U.S. citizen or a U.S. resident alien for tax purposes. **Please note:** The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

FRAUD NOTICE/WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signatures

Except as may be provided under the Conditional Receipt on page 5 of this application, Royal Neighbors will have no liability under this application unless and until: a) it has been received and approved by Royal Neighbors at its Home Office; b) the Certificate has been issued and delivered to the Certificateowner; c) the first premium has been paid to and accepted by Royal Neighbors; and d) at the time of delivery and payment, the facts concerning the insurability of the Proposed Insured are as stated in this application.

❑ **I acknowledge receiving and signing the Rider Disclosure Statement, Form 9745-A, from my agent, if applicable.**

SIGNATURES:

Signed at city, state _____ Date_____

Proposed Insured _____

Signed at city, state _____ Date_____

Proposed Owner _____
(If other than Proposed Insured)

Agent's Report

REPLACEMENT:

Do you have any knowledge or reason to believe the Proposed Insured has any existing or applied for life insurance or annuity contracts with this or any other company? ❑ Yes ❑ No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? ❑ Yes ❑ No

Do you have any knowledge or reason to believe that the Proposed Insured has in-force life insurance or annuity contracts that may be replaced as a result of this transaction? ❑ Yes ❑ No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? ❑ Yes ❑ No

Did you use only written sales material approved for use by Royal Neighbors? ❑ Yes ❑ No

Did you personally review a photo I.D. of the Proposed Insured? ❑ Yes ❑ No If Yes, form of I.D. _____

Did you personally review a photo I.D. of the Proposed Owner? ❑ Yes ❑ No If Yes, form of I.D. _____

Was interview completed at point-of-sale? ❑ Yes ❑ No

Was Rider Disclosure Statement, Form 9745-A, delivered and signed by you and the Proposed Insured and Proposed Owner, if applicable? ❑ Yes ❑ No

Note: Refer to language at top of Conditional Receipt for circumstances when Conditional Receipt should not be used.

Agent no. _____ Agent license no. _____

Signature of Writing Agent _____ Date _____

Printed name of Writing Agent _____

If applicable, complete the following:

Agent Name_____ ID Number _____ Percent _____
Please print

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Conditional Receipt

IMPORTANT: If face amount is over $400,000 or if within the past 12 months the Proposed Insured has been treated by a member of the medical profession for heart trouble, stroke, or cancer, payment (including authorization to draft the first premium) cannot be received with application and no conditional receipt may be given and there will be no coverage under any conditional receipt. If no check or money order is received with this application or funds from an IRS Section 1035 Exchange have not been received at the Home Office, then this conditional insurance is not effective and there will be no insurance in effect unless and until a certificate for the insurance applied for has been issued and delivered and the full amount of the premium due has been received at the Home Office of Royal Neighbors.

Unless each and every condition specified below is fulfilled exactly, no insurance will become effective prior to delivery of the Certificate of insurance. No agent of Royal Neighbors of America *(Royal Neighbors)* is authorized to alter or waive any of the conditions.

Received from _____ on *(Date)*_____ the sum of ❑ $_____ (in the form of a check or cashier's check only) / ❑ no money received with application in connection with an application to Royal Neighbors for the following insurance Certificate:
Proposed Insured: _____ Life Insurance Amount: $_____ Plan: _____

1. All of the following conditions must be met before insurance may become effective prior to delivery of the Certificate:
   a) The payment indicated above must be at least equal to the greater of $10,000 or the single premium necessary to pay the premium for the face amount applied for at the standard rate class. Assuming all the other conditions under this paragraph have been met, if Royal Neighbors, in accordance with its rules, would have issued the Certificate for a lesser amount than applied for, and the premium paid was at least equal to the premium that would have been required for the issuance of a certificate at this new face amount, then the death benefit payable under the receipt shall be such as the premium paid would have purchased.
   b) All medical examinations, records, and tests required by Royal Neighbors must be completed and received at the Home Office of Royal Neighbors.
   c) As of the effective date, as defined below, the Proposed Insured must be a standard risk under rules and practices of Royal Neighbors for the plan and the amount of life insurance applied for, without change and at the rate of premium paid.
   d) As of the effective date, the state of health and all factors affecting the insurance of the Proposed Insured must be as stated in the application.
2. When each and every one of the conditions of paragraph 1 have been met, the insurance coverage, as provided by the terms and conditions of the Certificate of life insurance applied for, but not greater than $400,000, will begin as of the Effective Date. "Effective Date" as used herein, means the later of:
   a) the date of completion of the application; or
   b) the date of completion of all medical examinations, electrocardiograms, blood/urine tests, and other tests required by Royal Neighbors; or
   c) the receipt in the Home Office of all funds from the Proposed Owner or through an IRS Section 1035 Exchange sufficient to meet the requirements for insurance coverage under paragraph 1.
3. If the conditions have been met and coverage begins, coverage under this receipt will terminate 60 days from the date of this receipt unless prior to that date the insurance Certificate is issued, delivered, and accepted.

NO AGENT OR OTHER PERSON IS AUTHORIZED BY ROYAL NEIGHBORS TO WAIVE OR MODIFY ANY OF THE PROVISIONS OF THE CONDITIONAL RECEIPT.

Signature of Agent Receiving the Payment_____

Signature of Proposed Insured _____

I understand and agree to the terms, conditions, and limits of this receipt and the agreements in the application, all of which have been fully explained to me by the agent.

Signature of Proposed Owner _____

This Page is to be detached, read, and retained by the Proposed Insured

MIB, Inc., Notice

Information regarding your insurability will be treated as confidential. Royal Neighbors or its reinsurers may make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or if a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Report Act. The address of MIB's information office is: MIB, 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

Royal Neighbors or its reinsurers may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Report Act Notice

This is to inform you that as part of our underwriting procedures in connection with this application, an investigative consumer report may be obtained on the Proposed Insured and the Proposed Owner. This report will provide applicable information concerning character, general reputation, personal characteristics, and mode of living.* This information will be obtained through personal interviews with neighbors, friends, and associates. You may request to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. No information collected concerning the sexual orientation of the Proposed Insured or Proposed Owner will be used to determine her or his eligibility for life insurance.
**Information obtained will not be used to determine sexual orientation.*

Notice of Potential Modified Endowment Contract

Section 7702A of the Internal Revenue Code places a limit on the amount and timing of premium payments for a life insurance contract. If the limit is exceeded, the contract becomes a Modified Endowment Contract (MEC).

Death benefits under a MEC are income tax free to the beneficiary. Any other value received from a MEC is referred to as a "distribution" and may result in an income tax liability. Distributions include cash withdrawals; cash surrender of the contract, loans, and assignment of the contract to another person or institution.

Distributions are first considered to be any gain under the contract and the gain is taxable in the year that it is received. In addition, a taxable distribution is subject to a 10% tax penalty if the taxpayer has not attained age 59 ½, subject to certain exceptions contained in the tax code. Also, distributions received in the two year period prior to the date the contract becomes a MEC may be taxable.

Distributions that exceed the gain under the contract are not taxable.

Tax laws are subject to change.

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Supplemental Questionnaire for Individual Life Insurance

SECTION 1 – PROPOSED INSURED

This is a supplement to the application for life insurance for:

Proposed Insured Name: _____

❑ Simplified Issue Whole Life ❑ Single Premium Whole Life ❑ Jet Whole Life ❑ Jet Term Life

Date of Application for Life Insurance: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City, State, ZIP: _____

SECTION 2 – PROPOSED INSURED MEDICAL INFORMATION

1. In the past 30 days, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for COVID-19 (the SARS Co-V-2 virus)? ❑ YES ❑ NO

2. In the past 30 days, has a member of the medical profession administered a test on you for COVID-19, for which the results have not been received, or recommended that you be tested for COVID-19 (the SARS Co-V-2 virus)? ❑ YES ❑ NO

3. In the past 30 days, have you been advised by a medical professional to self-quarantine? ❑ YES ❑ NO

4. In the past 30 days, have you been treated, examined or advised by a member of the medical profession, whether in person, by phone or by other electronic means, for fatigue, fever, cough, or shortness of breath? ❑ YES ❑ NO

NOTICE

Only for products offering Graded Death Benefits, the following language is stricken from the application:
"If question 8 and 9 are answered YES, only Graded Death Benefit is available."

AGREEMENT / ACKNOWLEDGMENT

This Supplemental Questionnaire is made part of my application for life insurance. I have read this Supplemental Questionnaire, and to the best of my knowledge and belief, all answers are true and correct. I understand and agree that (1) any insurance shall be issued by Royal Neighbors of America is dependent on these answers being complete and correct; and (2) the answers given in the application, this Supplemental Questionnaire, and any other amendments to the application will be the basis of any insurance issued.

FRAUD NOTICE / WARNING

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SIGNATURES

Signature of Proposed Insured: _____ Date: _____

Signature of Agent: _____ Date: _____

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Date of Birth: _____ Social Security Number: _____

Address: _____

City, State, ZIP: _____

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SIGNATURES

Signature of Proposed Insured: _____ Date: _____

Signature of Agent: _____ Date: _____