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

Application for Simplified Issue Individual Whole Life Insurance

❑ Mail certificate to agent

PART 1

SECTION 1 – Proposed Insured

Name _____ Street _____
City _____ ST _____ ZIP _____
SSN/Tax ID _____ Sex ❑ M ❑ F
Phone ( ) _____ DOB _____ State/Country of birth _____
❑ U.S. driver's license ❑ Green Card ❑ Passport ❑ Other _____
ID number _____ ID issuer _____ ID expiration date _____
Are you a U.S. citizen? ❑ Yes ❑ No If No, Permanent Resident ID # _____

SECTION 2 – Other Insurance

1. EXISTING or APPLIED FOR INSURANCE

Does the Proposed Insured have any existing or applied for life insurance or annuity contracts with this or any other company?

❑ Yes ❑ No **IF YES,** complete state replacement forms, if required, with this application. Provide details:

Company _____ ❑ Life Insurance ❑ Annuity Amount _____

2. REPLACEMENT

In connection with this application, has there been, or will there be, with this or any other company any: replacement of coverage; 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 state replacement forms, if required, with this application.

SECTION 3 – Proposed Owner

OWNER other than PROPOSED INSURED

Name _____ SSN/Tax ID _____
Street _____ Phone ( ) _____ DOB _____
City _____ ST _____ ZIP _____ Relationship to Proposed Insured _____
❑ U.S. driver's license ❑ Green Card ❑ Passport Are you a U.S. citizen? ❑ Yes ❑ No
❑ Other _____ If No, Permanent Resident ID # _____
ID number _____ ID issuer _____ ❑ Check if you wish ownership to revert to Insured upon Owner's death.*
ID expiration date _____ * There may be tax consequences. Please consult your tax advisor.*

SECTION 4 – Beneficiary(ies)

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

❑ **PRIMARY** (Percent of proceeds _____%)
Name _____
Street _____
City _____ ST _____ ZIP _____
DOB _____ SSN/Tax ID _____
Relationship to Proposed Insured _____

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

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

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

SECTION 5 – Information Regarding Specific Insurance Plan

1. LIFE INSURANCE PLAN

❑ Simplified Issue Whole Life ❑ Graded Death Benefit

2. RIDER

❑ Accelerated Living Benefit Rider (no additional premium; not available on face amounts below $7,000)

3. FACE AMOUNT $_____

4. AUTOMATIC PREMIUM LOAN will be provided.

❑ No Check if APL is NOT desired.

SECTION 6 – Payment Information

If **Electronic Payment** is chosen, complete EFT form on page 4.

1. PAYMENT MODE (Check one)

Direct bill: ❑ Annual ❑ Semi-Annual ❑ Quarterly

Electronic payment: ❑ Annual ❑ Semi-Annual

❑ Quarterly ❑ Monthly ❑ Payment with app $_____

❑ Draft first payment Payment quoted $_____

2. BILLING ADDRESS INFORMATION

❑ Proposed Insured's address ❑ Primary Owner's address

❑ Other Premium Payor's/Alternate billing address (details below)

Name _____

Street _____

City_____ ST_____ZIP_____

PART 2

SECTION 1 – Physician Information

Please provide name of doctor, 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/Clinic_____ City_____ ST_____ ZIP_____

List all currently prescribed medications: _____

_____

_____

SECTION 2 – Medical Questions

1. Has the proposed Insured used tobacco in any form in the last 12 months?	❑ Yes	❑ No
If any answer to questions 2 through 7 is YES, the Proposed Insured is not eligible for ANY coverage.		
2. Is the Proposed Insured currently:		
a. Hospitalized, in a nursing facility, or receiving Hospice Care?	❑ Yes	❑ No
b. Confined to a wheelchair, bed, or using oxygen equipment to assist in breathing?	❑ Yes	❑ No
3. Has a member of the medical profession ever diagnosed or treated the Proposed Insured for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any immune deficiency disease; or has the Proposed Insured tested positive for the Human Immunodeficiency Virus (HIV)?	❑ Yes	❑ No
4. Has the Proposed Insured ever been diagnosed as having or been treated for:		
a. Congestive heart failure, or had or been recommended to have an organ transplant?	❑ Yes	❑ No
b. Insulin shock, diabetic coma, amputation caused by disease, or taken insulin shots prior to age 30?	❑ Yes	❑ No
c. Dementia, Alzheimer's Disease, or mental incapacity?	❑ Yes	❑ No
5. During the past 18 months has the Proposed Insured been diagnosed as having:		
a. Stroke, aneurysm, cardiomyopathy, or circulatory surgery?	❑ Yes	❑ No
b. Angina (chest pain), heart attack or failure, or heart surgery?	❑ Yes	❑ No
6. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:		
a. Internal Cancer, Melanoma, or Leukemia?	❑ Yes	❑ No
b. Cirrhosis, liver disease, kidney failure (including dialysis), chronic kidney disease, or systemic lupus?	❑ Yes	❑ No
7. During the past 18 months, has the Proposed Insured been diagnosed as having:		
a. A condition expected to result in death within 12 months?	❑ Yes	❑ No
b. Been advised by a medical professional to have any diagnostic testing which has not been completed or for which the results have not been received?	❑ Yes	❑ No
c. Been recommended by a physician to have treatment or counseling for alcohol or drug abuse?	❑ Yes	❑ No
If question 8 or 9 is YES, only Graded Death Benefit is available.		
8. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:		
a. Stroke, angina (chest pain), heart attack, or cardiomyopathy?	❑ Yes	❑ No
b. Heart or circulatory surgery (including pacemaker, heart valve replacement, bypass, angioplasty, stent implant, or any procedure to improve circulation to the heart or brain)?	❑ Yes	❑ No
9. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:		
a. Emphysema, chronic obstructive pulmonary disease (COPD), or tuberculosis (TB)?	❑ Yes	❑ No
b. Neuromuscular disease (including Multiple Sclerosis, Lou Gehrig's Disease, Epilepsy, or Parkinson's Disease)?	❑ Yes	❑ No

Agreement/Acknowledgement

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

- My statements in the 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, become part of the new certificate.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in the 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.
- If not a current member, I, the Proposed Insured, hereby apply to become a member of Royal Neighbors as indicated by my signature on the application. As a member, I agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors was founded more than 100 years ago.

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, 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 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 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 from the date signed if used in connection with an application for 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.

NO IMMEDIATE LIFE INSURANCE COVERAGE: 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 owner; c) the first premium has been paid to and accepted by Royal Neighbors (If the first premium is to be electronically drafted, then the premium has not been "paid" until honored by the financial institution.); and d) at the time of delivery and payment, the facts concerning the insurability of the Insured are as stated in this application.

SIGNATURES:

Signed at city, state_____ Date_____

Proposed Insured _____

Signed at city, state_____ Date_____

Proposed Owner _____

(If other than Proposed Insured)

Agent's Report

Does the Proposed Insured applied for or have any existing life insurance or annuity contracts with this or any other company?
❑ Yes ❑ No **IF YES,** complete state replacement forms, if required, with this application. Provide details:
Company_____ ❑ Life Insurance ❑ Annuity Amount _____
In connection with this application, has there been, or will there be, with this or any other company any: replacement of coverage; 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 state replacement forms, if required, with this application.
Did you use only written sales material approved for use by Royal Neighbors? ❑ Yes ❑ No

Did you complete any required state disclosure statements? ❑ Yes **IF YES,** state(s): _____ ❑ No

Did you personally review the Owner's ID? ❑ Yes ❑ No Was the Proposed Insured with you at the time of the application? ❑ Yes ❑ No
Agent no._____ Agent license no._____

Certification: I certify that the information provided is true and complete.

Signature of Writing Agent _____ Date _____
Printed name of Writing Agent _____

If applicable, complete and sign the following statement*(s)*:

Agent Signature_____ Date _____
Agent Name _____ ID Number _____ Percent _____
Please print

Agent Signature_____ Date _____
Agent Name _____ ID Number _____ Percent _____
Please print

INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠

Royal Neighbors of America
230 16th St., Rock Island, IL 61201
(800) 627-4762
A Fraternal Benefit Society

Authorization for Electronic Funds Transfer (EFT)

I authorize Royal Neighbors of America (Royal Neighbors) and my financial institution to initiate automatic withdrawals from my checking/savings account. This authority will remain in effect until I notify Royal Neighbors or the bank to cancel it in such time as to afford a reasonable opportunity to act on the request. I can stop payment of any withdrawal by notifying Royal Neighbors three days before my scheduled withdrawal day. Royal Neighbors reserves the option to change the method of payment to another qualifying mode after the occurrence of a transaction not honored.

❑ **Check box to use bank information from attached voided check. Form must still be signed and payment selected.**

Name of financial institution _____
City _____ ST _____
Name (please print)_____ Phone number ( )_____
Street address/PO Box _____
City _____ ST_____ ZIP _____

I would like the payment withdrawn on the _____ day of the month
OR the _____2nd _____3rd _____4th Wednesday of the month. (If nothing is selected it defaults to the 5th day of the month.)
Routing No. _____ Checking account no. _____
OR Savings account no. _____

Debit card numbers are not acceptable.

Signature _____ Date _____

PLEASE RETURN THIS AUTHORIZATION WITH A VOIDED CHECK.

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

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.

MIB, Inc., Notice

Information regarding your insurability will be treated as confidential. Royal Neighbors of America (Royal Neighbors) or its reinsurers may make a brief report thereon to the 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 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, TTY (866) 346-3642. 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. 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 will be used to determine her or his eligibility for life insurance.

**Information obtained will not be used to determine sexual orientation.*

Royal Neighbors of America
230 16th St., Rock Island, IL 61201
(800) 627-4762 • www.royalneighbors.org

This page is intentionally left blank.

Royal Neighbors of America
230 16th St., Rock Island, IL 61201
(800) 627-4762 • www.royalneighbors.org

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

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: _____

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

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: _____

INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠

230 16th Street • Rock Island, IL 61201
(309) 788-4561 • (800) 627-4762
contact@royalneighbors.org • www.royalneighbors.org

Accelerated Living Benefit Rider Disclosure
For use with Rider Form Series 1766

PREMIUMS – There are no premiums charged for this rider. If the certificate to which the rider is attached requires regularly scheduled premiums, scheduled premium payments must be made to keep the certificate in force. If the premiums due are not paid and the certificate enters a grace period, the rider will be subject to all provisions of the certificate.

AN ACCELERATED LIFE INSURANCE BENEFIT MAY BE TAXABLE – The acceleration of life insurance benefits offered under this rider is intended to qualify for favorable tax treatment under the Internal Revenue Code. If the acceleration of life insurance benefits qualifies for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Whether such benefits qualify depends on factors such as the Insured's life expectancy at the time the benefits are accelerated and whether the accelerated benefits are used to pay for necessary long-term care expenses, such as nursing home care. Tax laws relating to the acceleration of life insurance benefits are complex. You are advised to consult with a qualified tax professional regarding the circumstances under which you might be able to receive an acceleration of a life insurance benefit, excludable from income under federal law.

Receipt of an acceleration of life insurance benefits may also affect your, your spouse, or family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. You are advised to consult with a qualified tax professional and with social service agencies regarding how receipt of such accelerated benefits may affect your, your spouse, and your family's eligibility for public assistance.

BENEFIT – The Accelerated Living Benefit Rider provides for a single lump sum payment of an accelerated life insurance benefit using a portion of your life insurance certificate's death benefit. Eligible proceeds are equal to 75% of the certificate's death benefit in force on the day Royal Neighbors receives the acceleration request, up to a maximum of $250,000. A minimum amount of at least $5,000 must be requested. **Only one acceleration for an insured will be allowed.**

This benefit is paid to the Owner of the life insurance certificate while the insured is living, provided the insured is diagnosed with a qualified terminal condition with a life expectancy of twelve (12) months or less, or the insured is permanently confined to a qualified nursing home, as provided under the terms of the rider. Royal Neighbors of America will require satisfactory evidence and a physician's statement certifying the insured's life expectancy in the event of a terminal condition; or, certification of permanent confinement in a qualified nursing home.

If the insured dies before the accelerated payment is made, the death benefit payable under the certificate will be paid to the beneficiary.

EFFECT OF ACCELERATION OF A BENEFIT – The accelerated benefit payment, administrative fee, and accrued interest constitute a lien on the life insurance certificate. Benefits payable at the death of the insured, and any cash or loan values available under the certificate will be reduced by any outstanding lien balance. At the time the accelerated benefit is paid, Royal Neighbors will provide the owner of the certificate with a statement specifying:

1. the amount of the accelerated benefit paid;
2. the effect of the accelerated benefit payment on the certificate's face amount, cash value, future premiums, loans and liens.

LIEN OF ACCELERATED BENEFIT – Royal Neighbors reserves the right to charge an administrative fee of $150, if allowed by law. The amount of the administrative fee will be deducted from the Accelerated Benefit payment.

Interest on the amount of the Accelerated Benefit and the administrative fee will accrue from the date Royal Neighbors pays the Accelerated Benefit to the date of the Insured's death, and shall constitute a lien on the certificate. At the time of the Insured's death, the Death Benefit will be reduced by the amount of the Accelerated Benefit plus the accrued interest, the amount of any outstanding loans, and past due premiums, if any.

The interest rate applied to the Accelerated Benefit and the administrative fee shall be as set by Royal Neighbors and in effect at the time of payment of the Accelerated Benefit, but will not exceed the certificate loan interest rate stated in the certificate.

The Owner may only withdraw any portion of the certificate's cash value or obtain a loan on any portion of the certificate's loan value which exceeds the amount of the lien of the Accelerated Death Benefit, and any outstanding certificate loans, or reserve impairments, if any.

ELIGIBILITY – The Owner of the certificate to which this rider is attached is not eligible for payment of the accelerated benefit under this rider if:

- the Owner is required, by law, to use any payment to meet the claims of creditors, whether due to bankruptcy or otherwise; or
- the Owner is required by a government agency to use the payment in order to apply for, obtain, or keep a government benefit or entitlement; or
- the certificate to which this rider is attached is subject to any restriction imposed by any court order or rule of law; or
- the certificate to which this rider is attached has been continued as Extended Term Insurance (ETI) or as a Reduced Paid Up certificate (RPU).

COLLATERAL ASSIGNEES AND IRREVOCABLE BENEFICIARIES – Collateral assignees and irrevocable beneficiaries must sign a written consent to the payment of an accelerated benefit before such payment may be made to the Owner of the certificate. The written consent must be received at the Home Office in a form acceptable to Royal Neighbors of America before the date the accelerated benefit is paid.

TERMINATION – This rider will terminate and cease to be in force at the earliest of the following:

1. when the certificate to which it is attached terminates.
2. when a non-forfeiture option is elected.
3. on any date by prior written request of the Owner in proper form. Return of the certificate to the Home Office for proper endorsement may be required.

The certificate, to which this rider is attached, will terminate at any time the indebtedness, including any lien balance and certificate loans and reserve impairments, if any, plus accrued interest, exceeds the certificate's Death Benefit.

ASSIGNMENT – The Owner may not assign this rider or the Accelerated Benefit payments made under this rider.

FILING A CLAIM – Royal Neighbors will pay the Owner the benefits due under the Accelerated Living Benefit Rider upon receipt of a written request from the Owner, and due proof at the Owner's expense that the Insured has been diagnosed with a qualified terminal condition, or permanently confined to a qualified nursing home, pursuant to the terms of the rider. Due Proof includes, but is not limited to, a statement signed by a licensed physician that the Insured has been diagnosed with a qualified terminal condition, or is permanently confined to a qualified nursing home. Royal Neighbors of America reserves the right to require, at Royal Neighbors' expense, an exam by a physician of Royal Neighbors' choice in order to confirm that the Insured has a qualified condition or confinement, and to request documents that support the qualified condition diagnosis from the Insured's attending physician.

SAMPLE ILLUSTRATION – The sample illustration below assumes: (1) a $100,000 death benefit; (2) that there are no outstanding loans on the certificate; (3) the entire available accelerated benefit is paid; (4) the interest rate on the lien is 8% per annum; and (5) the administrative fee is $150.

Before payment of the accelerated benefit

Certificate Death Benefit	$100,000
Available Accelerated Benefit (lesser of 75% of certificate face or $250,000)	$ 75,000
Accelerated Benefit Payment	$ 75,000
Initial Lien Amount on Certificate	$ 75,000
LESS – Administrative Fee	$ 150
Net Payment to the Owner	$ 74,850

If Death Occurs Immediately After Accelerated Benefit Is Paid

Certificate Death Benefit	$100,000
LESS – Initial Lien Amount	$ 75,000
Net Death Proceeds Payable At Death Of The Insured	$ 25,000

If Death Occurs Six (6) Months After Accelerated Benefit Is Paid

Certificate Death Benefit	$100,000
LESS – Initial Lien Amount	$ 75,000
LESS – Accrued Interest on the Lien Amount	$ 2,943
Net Death Proceeds Payable At Death Of The Insured	$ 22,057

Proposed Owner Signature _____ Date _____

Agent Signature _____ Date _____

INSURING LIVES
SUPPORTING WOMEN
SERVING COMMUNITIES℠

Royal Neighbors of America
230 16th Street • Rock Island, IL 61201
(309) 788-4561 • (800) 627-4762
contact@royalneighbors.org • www.royalneighbors.org

IMPORTANT INFORMATION – FOR USE WITH APPLICATIONS COMPLETED ELECTRONICALLY

This document contains important consumer disclosure notices and application agreements, acknowledgments, and authorizations. The applicant must read this document prior to completing the application and must retain a copy for their records.

During the application process, the proposed insured will be asked to acknowledge and agree to the terms of this document, which includes the Authorization, MIB, Inc. Notice, Fair Credit Report Act Notice, Agreement/Acknowledgement, and Fraud Notice Warning below. These items will become part of the application completed and signed by the proposed insured.

Consumer Disclosure Notices

MIB, Inc., Notice

Information regarding your insurability will be treated as confidential. Royal Neighbors of America (Royal Neighbors) or its reinsurers may make a brief report thereon to the 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 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, TTY (866) 346-3642. 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. 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 will be used to determine her or his eligibility for life insurance.

**Information obtained will not be used to determine sexual orientation.*

Application Agreements, Acknowledgments, and Authorizations

Agreement/Acknowledgement

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

- My statements in the 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, become part of the new certificate.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in the 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.
- If not a current member, I, the Proposed Insured, hereby apply to become a member of Royal Neighbors as indicated by my signature on the application. As a member, I agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors was founded more than 100 years ago.

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, 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 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 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 from the date signed if used in connection with an application for 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.

NO IMMEDIATE LIFE INSURANCE COVERAGE: 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 certificatowner; 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 Insured are as stated in this application.

The proposed insured's signature will appear at the end of the application for insurance, directly below this Authorization.