



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, 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?

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?

IF YES, complete state replacement forms, if required, with this application.

SECTION 3 – Proposed Owner

OWNER other than PROPOSED INSURED

Name, Street, City, ST, ZIP, SSN/Tax ID, Phone, DOB, Relationship to Proposed Insured, U.S. driver's license, Green Card, Passport, Other, ID number, ID issuer, ID expiration date, Are you a U.S. citizen?, If No, Permanent Resident ID #, Check if you wish ownership to revert to Insured upon Owner's death.\*

SECTION 4 – Beneficiary(ies)

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

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 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.

## NOTICE

**ROYAL NEIGHBORS OF AMERICA IS LICENSED TO DO BUSINESS IN THE STATE OF ILLINOIS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN THE ILLINOIS LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOWN AS THE GUARANTY ASSOCIATION). THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY.**

**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

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## 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.**

### 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](http://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.*

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(800) 627-4762 • [www.royalneighbors.org](http://www.royalneighbors.org)



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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. Within the last 30 days, have you been diagnosed, treated, or been given medical advice by a licensed member of the medical profession for a new or unexplained continuous cough, a high temperature or fever, chest pain, severe digestive pain, severe fatigue, breathing difficulties and/or symptoms associated with COVID-19? [ ] 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.

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SIGNATURES

Signature of Proposed Insured: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Agent: \_\_\_\_\_ Date: \_\_\_\_\_