Application for Juvenile Term Insurance and Membership

Catholic Holy Family Society • 2021 Mascoutah Ave. • PO Box 327 • Belleville, IL 62222-0327

PLEASE PRINT

1. CHILD TO BE INSURED First name	Middle Initial	Last	Gender ❑ M ❑ F
Address	City	State	Zip Code
Social Security Number	Date of Birth	Age	Telephone
2. BENEFICIARY First name	Middle Initial	Last	Relationship

3. I wish to apply for coverage in the amount of: ❑ $10,000 ❑ $25,000 ❑ $50,000

4. Will any life insurance or annuity policy be replaced or changed because of this application? ❑ Yes ❑ No
(If "Yes", complete required replacement form(s) and attach.)
Company _____ Policy Number _____

5. Do you have existing life insurance or annuity contracts with the company or any other company? ❑ Yes ❑ No
Details (Furnish complete name of Issuing Company, Policy Number, amount of insurance.)

_____

6. What is the child to be insured's current: Height: _____ ft. _____ in. Weight: _____ lbs.

7. If the child has siblings, does each child have an equal amount of life insurance coverage? ❑ Yes ❑ No

8. Has the child to be insured ever been diagnosed or treated by a member of the medical profession for:

a. cancer	❑ Yes	❑ No
b. stroke	❑ Yes	❑ No
c. any deformity, congenital defect or abnormal development	❑ Yes	❑ No
d. diabetes	❑ Yes	❑ No
e. any heart disorders	❑ Yes	❑ No
f. any liver disorders	❑ Yes	❑ No
g. any respiratory disorders	❑ Yes	❑ No
h. any intestinal disorders	❑ Yes	❑ No
i. any urinary disorders	❑ Yes	❑ No
j. any mental or emotional disorders	❑ Yes	❑ No
k. any neurological disorders	❑ Yes	❑ No

9. Has the child to be insured ever been diagnosed or treated by a member of the medical profession for: any immune deficiency disorders, Acquired Immune Deficiency Syndrome, Acquired Immune Deficiency Syndrome related complex, or within the past three (3) years test results indicating exposure to the Acquired Immune Deficiency Syndrome virus? ❑ Yes ❑ No

10. Has the child received any medical advice, examination, or treatment other than regular pediatric examinations, immunization shots or treatment for childhood disease within the past 5 years? ❑ Yes ❑ No

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11. Provide details for any question 8 through 10 that was answered "Yes".

12. APPLICANT/OWNER First name	Middle Initial	Last	Relationship to Child

Address	City	State	Zip Code

Social Security Number	Date of Birth	Age	Telephone

Contingent Owner (If Applicant/Owner Dies) First name	Middle Initial	Last	Relationship to Child

I am the parent, grandparent or guardian and I hereby declare that I have read the foregoing questions and represent each answer to be true and complete to the best of my knowledge and belief. I UNDERSTAND that the Company will rely on my answers and that no insurance will take effect until the premium has been paid and a certificate has been issued while the Insured is living.

FRAUD STATEMENT

I hereby acknowledge and accept the full text of the Fraud Statement as follows: 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.

Catholic Holy Family Society 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.

Signed at _____ X _____

City State Date Applicant/Owner Signature

CONDITIONAL RECEIPT

All premium checks must be made payable to CATHOLIC HOLY FAMILY SOCIETY

Received from _____ this _____ day of _____ 20_____.

The sum of $_____ in connection with an application for Juvenile Term Life Insurance in the Amount of $_____ as shown on the application on _____, the Proposed Insured.

_____

Signature of Licensed Agent