

WESTERN CATHOLIC UNION, A FRATERNAL BENEFIT SOCIETY

Application – Form Please print, use dark ink

1. PROPOSED INSURED:

Name: _____
First Mi Last Male
Female
Date of Birth: _____ Ht.: _____ Wt.: _____ Occupation: _____
Social Security No.: _____ Telephone No.: _____

2. PLAN:

a. Face Amount: \$ _____ b. Premium: \$ _____ c. Premium Mode: _____
d. Dividend Option: Cash. Reduce Premium. Accumulate. Paid Up Addition.

3. OWNER: Proposed Insured Other; show name, relationship, and

Social Security No.: _____
No. Street City State Zip
Address: _____

4. BENEFICIARY: (Show name, relationship and share.)

5. Will the insurance applied for replace or change any in-force life insurance or annuity?

Proposed Insured: No. Yes. If Yes, show the policy number(s) and name of insurer in 8.

6. a. In the past 5 years, has the person insured for insurance: (1) received treatment from a duly licensed medical practitioner; or (2) been treated in a medical care facility, for: cancer, tumor or malignancy; diabetes; emphysema; epilepsy; heart or circulatory disease or disorder; mental or nervous disease or disorder; stroke; kidney, liver or genito-urinary disease or disorder; or, the use of alcohol or non-prescription drugs? No. Yes.

b. In the past 5 years, has the proposed insured been treated by a duly licensed medical practitioner for Acquired Immune Deficiency Syndrome (AIDS)? No. Yes.

Any Yes answer, circle condition and show the condition and the name and address of the medical practitioner and/or medical care facility in 8.

7. In the past 2 years, has the proposed insured used tobacco in any form? No. Yes; give details in 8.

8. DETAILS: (If additional space is needed, use a separate sheet, dated and signed.)

(continued on reverse)

Form LSF0604

-WESTERN CATHOLIC UNION

510 Main Street
Quincy, IL 62301

Conditional Receipt

This receipt does not provide any insurance until its conditions are met.

Received from: _____, in connection with an application for insurance on the life of: _____, the sum of: \$ _____.

Date: _____ Agent: _____

Please contact Western Catholic Union if you do not receive the contract applied for or a refund of the amount paid within 60 days from the date of this receipt. Please include the name of the agent and the date and amount paid.

All remittances must be payable to Western Catholic Union. Do not make payable to the Agent or leave the Payee blank.

Form LSF0604

MEDICAL INFORMATION BUREAU (MIB). Information regarding your insurability will be treated as confidential. Western Catholic Union, or its reinsurer, may, however, make a brief report thereon to the MIB which is a non-profit organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member for life or health insurance coverage, or if a claim for benefits is submitted to such member, the MIB, on request, will supply such member with the information it may have in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information, you may contact the MIB and seek a correction in accordance with procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB information office is: P.O. Box 105, Essex Station, Boston, MA 02112; telephone (617)426-3660.

Having read the above statements and answers, we represent that, to the best of our knowledge and belief, the statements and answers are true and complete. We understand that this application shall be the basis for and a part of any contract issued.

We understand and agree that no insurance shall take effect unless and until: (1) this application is approved by the Society at its Home Office; (2) an insurance contract is issued, delivered to and accepted by its owner; and (3) the full first premium for the insurance is paid. All such conditions must be met while the health and other factors affecting the insurability of the Proposed Insured remain as described in this application.

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FRAUD WARNING

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

AUTHORIZATION. We hereby authorize any: physician or medical practitioner; hospital, clinic or other medically related facility; insurer or reinsurer; the Medical Information Bureau (MIB); employer, institution or person, that has any information regarding the undersigned Proposed Insured to provide such information to: Western Catholic Union or its reinsurer; or, except for the MIB, its legal representative. The information thus obtained will be used to determine eligibility for insurance or benefits. Such information will be treated as confidential and will not be disclosed except to: Western Catholic Union's reinsurer; the MIB; persons or organizations performing business or legal services in connection with this application or a claim for benefits; or, as may be legally required. This Authorization shall be valid for a period of 24 months from the date shown below. A photocopy shall be as valid as the original. The Proposed Persons Insured understand that, on request, they may receive a copy of this Authorization.

Signed at _____ this _____ day of _____, _____

Proposed Person Insured _____

Owner, if not Proposed Insured: _____

Member Applicant: _____

Witness _____

licensed representative

Form No. LSF0604

The insurance applied for will be effective on the later of: (1) the application date; or (2) the date of any initially required medical examination; provided, the following conditions are met: (1) the Proposed Insured is found to be standard risks for the amount and plan applied for in accordance with Western Catholic Union's underwriting rules then in effect; (2) the amount paid is not less than the first premium for the amount and plan applied for; and (3) the payment is good and collectible. The maximum amount of life insurance which may become effective under this Conditional Receipt: may not exceed \$100,000 which includes any other pending application for the Proposed Insured.