

**Fraud Warning**  
 Any person who, with 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.

Are You a Practicing Catholic? \_\_\_\_\_ Certificate # \_\_\_\_\_

**LIFE INSURANCE APPLICATION**

Council # \_\_\_\_\_

- Please Print in Dark Ink Only -

**A. IDENTIFICATION OF PROPOSED INSURED**

1. Full Name of Proposed Insured: \_\_\_\_\_  Male Birthdate: \_\_\_\_\_  
 \_\_\_\_\_  Female Age: \_\_\_\_\_

2. Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone Number \_\_\_\_\_  
 ( )

3. Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 4. Used Tobacco of **Any** Form in the Past 12 Months?  Yes  No

5. Height \_\_\_\_\_ 6. Weight \_\_\_\_\_ Weight Gain/Loss in Past Year? Explain: \_\_\_\_\_

**QUESTIONS 7 - 8 REFER TO PROPOSED INSURED IF 16 OR OVER, OR TO APPLICANT IF PROPOSED INSURED IS UNDER AGE 16**

7. Name of Employer: \_\_\_\_\_ Address: \_\_\_\_\_

8. a. Occupation: \_\_\_\_\_ How Long Employed? Years \_\_\_\_\_  
 b. Describe Duties \_\_\_\_\_

**B. THE INSURANCE**

1. Basic Plan: \_\_\_\_\_ 2. Amount of Insurance: \$ \_\_\_\_\_ 3. Premium: \$ \_\_\_\_\_

4. Riders w/this Plan:	Amount:	Premium:	5. Premiums to be Paid:
a. <input type="checkbox"/> Waiver of Premium	_____	_____	<input type="checkbox"/> Single Premium
b. <input type="checkbox"/> Accidental Death	_____	_____	<input type="checkbox"/> Annual
c. <input type="checkbox"/> Term Rider	_____	_____	<input type="checkbox"/> Semi-Annual
d. <input type="checkbox"/> APUAR e. <input type="checkbox"/> SPUAR	_____	_____	<input type="checkbox"/> Quarterly
TOTAL INCLUDING BASIC PREMIUM \$ _____			<input type="checkbox"/> Check-O-Matic ( 2 Months Required)

6. Amount Paid w/Application: \$ \_\_\_\_\_ 7. Automatic Premium Loan?  Yes  No

8. Dividend Election:  Paid Up Additions  Cash  Left on Deposit  Reduce Premium \_\_\_\_\_

9. PRIMARY BENEFICIARY(S) will receive proceeds unless changed by the Owner. List full name, relationship and birthdate. If no relationship, give address. Please list additional names or information on reverse side.  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_  
 CONTINGENT BENEFICIARY(S): List full name and relationship.  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_

10. Name of Owner : \_\_\_\_\_ 11. Relationship \_\_\_\_\_ 12. Birthdate \_\_\_\_\_

13. Address (if different from No. A2): \_\_\_\_\_ 14. Telephone Number \_\_\_\_\_  
 ( )

**C. INSURABILITY – Proposed INSURED. Do not complete section if medical exam is required.**

1. Has proposed insured ever had any disease or disorder of: \_\_\_\_\_ 2. Has proposed insured ever had any symptoms of or been affected with: \_\_\_\_\_  
 (If YES, circle condition and give details in Number 3)

a. Nervous system, epilepsy, convulsions, or paralysis? <input type="checkbox"/> Yes <input type="checkbox"/> No	a. Cancer, tumor, diabetes, glands; or blood disorders including HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. The heart or blood vessels; chest pains; high or low blood pressure, rheumatic fever? <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Any serious illness, disease or injury not already listed: <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Stomach, liver, intestines, gall bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No	c. Consultation, treatment or been examined by a physician or other practitioner for any other reason? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Kidney, urinary, bladder, prostate, reproductive organs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Lungs, asthma, tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	

3. Give complete details of any "YES" answers to Questions C1 and C2. Also, give FULL NAMES, ADDRESSES AND PHONE NUMBERS OF PHYSICIANS SEEN OR HOSPITALS USED WITHIN THE LAST 5 YEARS. Include dates, nature of disease or injury and treatment. \_\_\_\_\_

Form SF00-01

**CATHOLIC LADIES OF COLUMBIA** CONDITIONAL RECEIPT  
 THIS RECEIPT DOES NOT PROVIDE ANY INSURANCE UNTIL ITS CONDITIONS ARE MET – (SEE REVERSE SIDE)  
 Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_, intended to be the first full payment on a proposed life insurance Certificate for \$ \_\_\_\_\_, on the life of \_\_\_\_\_ referred to as the proposed insured.  
 CLC Representative: \_\_\_\_\_ # \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
 Please contact Catholic Ladies of Columbia at 1-800-845-0494 if you do not receive the certificate applied for or a refund of the amount paid within 60 days from the date of this receipt. Please include the name of the representative and the date and amount paid.  
**ALL REMITTANCES MUST BE PAYABLE TO CATHOLIC LADIES OF COLUMBIA (CLC).** Do not make payable to the Representative or leave payee blank.

4. Have you been treated for alcoholism or any drug habit?  Yes  No If yes, give date and explain below.

5. Have you been in a hospital, clinic, sanatorium, or institution for examination, observation, diagnosis, operation, or treatment?  
 Yes  No If yes, give date and explain

6. FAMILY RECORD:

LIVING

DECEASED

a. AGES STATE OF HEALTH AGES STATE OF HEALTH

Father

Mother

Brothers/Sisters

b. Have you a family history of coronary heart disease, cancer (except skin cancer), or any chronic illness or disease?

Yes  No If yes, explain: \_\_\_\_\_

**D. OTHER ITEMS**

- Amount of life insurance in force on life of proposed insured: Other companies? \_\_\_\_\_ With CLC? \_\_\_\_\_
- Has proposed insured had life or health insurance: rejected; rated up; postponed; modified; cancelled; or not renewed?  
 Yes  No If yes, explain when? \_\_\_\_\_ What company? \_\_\_\_\_
- Will insurance applied for replace or change any insurance or annuities?  
 Yes  No If yes, what company? \_\_\_\_\_ Amount? \_\_\_\_\_
- Have you been convicted of any moving traffic violations in the past five years?  Yes  No If yes, give details below.
- Has proposed insured ever engaged in or intend engaging in any type of flying as pilot or crew member, scuba or sky diving, racing, or other hazardous activities or do you contemplate any foreign travel in the next 24 months?  Yes  No If yes, give details \_\_\_\_\_
- Do you as applicant declare on behalf of yourself and any person who shall have an interest in any contract issued hereunder, that you have read each of the above answers and that to the best of your knowledge and belief they are full, complete and true?  Yes  No
- Do you as applicant agree that acceptance of the certificate with copy of this application attached constitutes ratification by applicant of corrections and additions by the Society in space below except there can be no change of amount, classification, age at issue, kind of plan of insurance or benefits, unless agreed to in writing?  Yes  No

NOTES:

**NOTICE TO PROPOSED INSURED**

I understand that information regarding my insurability will be treated as confidential. The Catholic Ladies of Columbia and its reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should I apply to another Bureau member company for life or health insurance coverage, or if a claim for benefits is submitted to the Bureau, upon request, will supply such company with the information it may have in its files. The Catholic Ladies of Columbia or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon receipt of a request from me, the Bureau will arrange disclosure of any information it may have in my file. (Medical information will be disclosed to my attending physician only). Should I have questions regarding the accuracy of information in the Bureau's file, I may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is PO Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

I further understand that in connection with this application for insurance, an investigative consumer report may be made as to my insurability, whereby information may be obtained through interviews with neighbors, friends and associates, and which may include, if applicable, information to character, general reputation, personal characteristics and mode of living. The consumer may inquire whether or not an investigative consumer report was requested, and if so, shall be given the name and address of the investigative consumer reporting agency to obtain a copy of the report.

**AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Catholic Ladies of Columbia, or its representatives, including Equifax or bearer, or reinsurer, any such information. The Catholic Ladies of Columbia may disclose such information to its reinsurer(s) or the Medical Information Bureau. This authorization is valid for 30 months after the date shown below.

A photographic copy of this authorization shall be as valid as the original.

I agree that no insurance shall take effect unless and until: (1) the first premium shall have been paid; (2) a certificate is delivered to the applicant during the Proposed Insured's lifetime; (3) the health of the Proposed Insured is as described in the application.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Proposed Insured Signature of Owner If Other Than Proposed Insured  
(Parent or Guardian, if Applicant is under age 16)

Owner Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CLC Representative: \_\_\_\_\_ No. \_\_\_\_\_ Phone No. (\_\_\_\_\_) \_\_\_\_\_

**CONDITIONS:** If the application be unconditionally approved by the Association at its Home Office, for the amount and at the rate applied for, and if also the applicant at the date of this receipt is an acceptable insurance risk under the Association's rules, the insurance so applied for, but in no event for more than \$25,000, shall be effective from the date of this receipt. In case the application is not so unconditionally approved or should it be found that the applicant was not an acceptable insurance risk on this date, no insurance shall be in force under this receipt. This receipt is of no force and effect unless it is for the whole amount of the first payment called for in the proposed Membership Certificate, nor unless such amount has been paid to the Representative of record. It is valid only for the initial payment on the proposed insurance.

I acknowledge possession of this receipt and I declare that I have read it and the agreement in the application. The terms, conditions, and LIMITS PROVISION of this receipt, to which I agree, and the agreement in the application have been explained to me fully by the CLC Representative and I understand them.

Signature of Applicant: \_\_\_\_\_

