Polish Beneficial Association
A Fraternal Benefit Society
(Herein called PBA)
2595 Orthodox Street Philadelphia, PA 19137
1-215-535-2626

Use this form for the following amounts:

Age	Under
0 – 50	$10,001
51 – 65	7,501
66 – 70	2,001
OR	
Term to 30	$25,001

Application for Life Insurance

Is applicant a member of the Polish Beneficial Association? ❑ Yes ❑ No. If not, apply for membership. Group: ________________

1. Full name (print): ______________________________ Phone Number: ______________________
2. Complete Address: ______________________________ City: ____________ State: ________ Zip: ________
3. Date of Birth: Month ________ Date ________ Year ________; Place of Birth: ______________________
4. Sex: ______ Social Security No.: ______________________ Height: ______ft.______in Weight: _______lbs.
5. Occupation: ______________________ 6. Employer: ______________________

7a. Name and Address of Beneficiary: ____

______________________________ And Relationship to Applicant: ________________

7b. Contingent Beneficiary: ______________________ Relationship to Applicant? ________________

Address: ______________________________

7c. Owner, if other than proposed insured: ________________ Relationship? ______________________

8. Is this insurance intended to replace or change any insurance or annuity now in force?
❑ Yes ❑ No If yes, give details: ____

9a. Within the last 5 years has Proposed Insured been hospitalized or received medical treatment or advice for any illness, disease, injury of physical condition? ❑ Yes ❑ No

9b. Does Proposed Insured have any physical or medical handicaps? ❑ Yes ❑ No

9c. Give details of **YES** answers to 9a and 9b. (Illness or handicap, dates, duration, physicians and/or hospital):

____

____

10. Plan of Insurance: ______________________________ Amount of Insurance: ______________________

Rider/s: ____ Premium: $ ______________________

Method of Payment: ❑ Single Premium ❑Annual ❑Semi-Annual ❑Quarterly

11. Do you as applicant declare 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

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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; (4) the Proposed Insure has been obligated in due form; and (5) all requirements of the Constitution and By-laws have been complied with.

Signed at ______________________________ this ________ day of ________________, 20 ________

______________________	______________________	______________________
Signature of Agent or Proposer	Proposed Insured's Signature	Proposed Insured's Signature (Parent or Guardian if applicant is under age 16.)

SF-94

AUTHORIZATION

I hereby authorize any licensed physician; medical practitioner; hospital; clinic; or other medical; or medically related facility; insurance company; or other organization; institution; or person, that has any records or knowledge of me or my health, to give to the Polish Beneficial Association, or, its representatives, including Equifax; or bearer; or reinsurer, any such information. This authorization is valid for no longer than 30 months. A photographic copy of this authorization shall be as valid as the original.

Date: ______________________, 20 ________

____
Proposed Insured's Signature

____
Signature of Agent or Proposer

____
Adult Applicant's Signature (If Proposed Insured is under age 16.)

See Fraud Notice on Reverse Side.

Fraud Warning Notice

Any person, who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.