200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173
847-342-4500
info@1891FinancialLife.com
www.1891FinancialLife.com

INDIVIDUAL LIFE INSURANCE APPLICATION

HOME OFFICE USE: Certificate _____ Effective Date _____ Court/Impact Team _____ Roster _____

IS INSURED A MEMBER OF 1891 FINANCIAL LIFE ("the Society")?

☐ Yes If known, please include: Court / Impact Team No. ____ Roster No. _____

☐ No If No, is Insured a member of the Catholic Church or the relative of a member of the Catholic Church? ☐ Yes ☐ No

PLAN INFORMATION - *please print full legal names*

INSURED

First Name _____ Middle Name _____ Last Name _____

Address / Apt. No. _____ City _____ State _____ Zip _____

Primary Phone No. _____ Alternate Phone No. _____ E-Mail Address _____

SSN / TIN _____ DOB MM/DD/YYYY _____/_____/_____ Age _____ Birth State _____ Gender: ☐ M ☐ F

Driver's License State & No. _____ Occupation _____ Employer _____

Annual Income _____ Net Worth _____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Civil Union

Has Insured used any tobacco, nicotine, nicotine substitution product, or nicotine delivery device in the last 3 years?

☐ Yes ☐ No If Yes, provide type(s) _____ and date of last use (Month) ____(Year) ____

OWNER - *if other than Insured (For Trust, use First Name line only and include Trust Date and Trustee Names)*

First Name _____ Middle Name _____ Last Name _____

Address / Apt. No. _____ City _____ State _____ Zip _____

Primary Phone No. _____ Alternate Phone No. _____ E-Mail Address _____

SSN / TIN _____ DOB MM/DD/YYYY _____/_____/_____ Age _____ Gender: ☐ M ☐ F

Driver's License State & No. _____ Occupation _____ Employer _____

Annual Income _____ Net Worth _____ Relationship to Insured _____

COVERAGE DETAILS

Face Amount $_____

WHOLE LIFE

Plan: **Simplified Issue Whole Life:** *Please use separate application: Form ICC23AP-LIFE-SI*

Plan: ☐ **LP@100** ☐ **LP@75** ☐ **20-Pay** ☐ **10-Pay**

Riders: ✓ Living Benefit Rider, Qualifying Event/Terminal Illness
☐ *WP* ☐ *ADB $*_____ ☐ *GIO $*_____ ☐ *LT10 $*_____ ☐ *LT20 $*_____
☐ Charitable Rider: Name of Charity _____ % _____

Plan: ☐ **SPWL**

Riders: ✓ Living Benefit Rider, Qualifying Event/Terminal Illness
☐ *SGIO $*_____ ☐ Charitable Rider: Name of Charity _____ % _____

TERM LIFE

Plan: ☐ **10-Yr LPT** ☐ **20-Yr LPT** ☐ **30-Yr LPT**

Riders: ✓ Living Benefit Rider, Qualifying Event/Terminal Illness ☐ *WP* ☐ *ADB* $_____

Plan: ☐ **Juvenile Term:**
Mode: ☐ Single ☐ Annual Face Amount: ☐ $18,910 ☐ $50,000

Dividend Option: ☐ Paid-Up Additions ☐ Paid in Cash ☐ Reduce Premium ☐ Accumulate at Interest

Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Modal Premium (=Amount Collected) $_____

Bill By: ☐ EFT – *include form* ☐ Debit/Credit Card – *include form* ☐ Direct (not available for Monthly Mode)

Do you elect the Automatic Premium Loan Privilege for Whole Life Plans? ☐ Yes ☐ No

Payor – *if other than Owner or Insured*

First Name _____ Middle Name _____ Last Name _____

Address / Apt. No. _____ City _____ State _____ Zip _____

Primary Phone No. _____ Alternate Phone No. _____ E-Mail Address _____

SSN / TIN _____ DOB MM/DD/YYYY _____/_____/_____ Age _____ Birth State _____ Gender: ☐ M ☐ F

Driver's License State & No. _____ Occupation _____ Employer _____

Annual Income _____ Net Worth _____ Relationship to Insured _____

REPLACEMENT INFORMATION

Does the Insured have any existing or pending life insurance or annuity contracts with the Society or any other company?
☐ Yes (please list below) ☐ No

Is the insurance applied for intended to replace or change any life insurance or annuity contracts in force with the Society or any other company?
☐ Yes (indicate below and complete Replacement Form) ☐ No

Name of Company	Date of Issue	Life Amount	ADB Amount	Purpose (Business/Personal)	Replacement?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

BENEFICIARIES - *Use whole numbers for percentages; the allocation total for each class must equal 100%*

☐ **PRIMARY** ☐ **CONTINGENT** ☐ **TRUST** ***(use First Name line only and include Trust Date and Trustee Names)***

First Name ____ Last Name ____ Gender: ☐ M ☐ F ____% Percentage

Address / Apt. No. ____ City ____ State ____ Zip ____

Primary Phone No. ____ Alternate Phone No. ____ E-Mail Address ____

SSN / TIN ____ DOB (MM/DD/YYYY) ___/___/___ Relationship ____

☐ **PRIMARY** ☐ **CONTINGENT** ☐ **TRUST** ***(use First Name line only and include Trust Date and Trustee Names)***

First Name ____ Last Name ____ Gender: ☐ M ☐ F ____% Percentage

Address / Apt. No. ____ City ____ State ____ Zip ____

Primary Phone No. ____ Alternate Phone No. ____ E-Mail Address ____

SSN / TIN ____ DOB (MM/DD/YYYY) ___/___/___ Relationship ____

☐ **PRIMARY** ☐ **CONTINGENT** ☐ **TRUST** ***(use First Name line only and include Trust Date and Trustee Names)***

First Name ____ Last Name ____ Gender: ☐ M ☐ F ____% Percentage

Address / Apt. No. ____ City ____ State ____ Zip ____

Primary Phone No. ____ Alternate Phone No. ____ E-Mail Address ____

SSN / TIN ____ DOB (MM/DD/YYYY) ___/___/___ Relationship ____

☐ **PRIMARY** ☐ **CONTINGENT** ☐ **TRUST** ***(use First Name line only and include Trust Date and Trustee Names)***

First Name ____ Last Name ____ Gender: ☐ M ☐ F ____% Percentage

Address / Apt. No. ____ City ____ State ____ Zip ____

Primary Phone No. ____ Alternate Phone No. ____ E-Mail Address ____

SSN / TIN ____ DOB (MM/DD/YYYY) ___/___/___ Relationship ____

☐ **PRIMARY** ☐ **CONTINGENT** ☐ **TRUST** ***(use First Name line only and include Trust Date and Trustee Names)***

First Name ____ Last Name ____ Gender: ☐ M ☐ F ____% Percentage

Address / Apt. No. ____ City ____ State ____ Zip ____

Primary Phone No. ____ Alternate Phone No. ____ E-Mail Address ____

SSN / TIN ____ DOB (MM/DD/YYYY) ___/___/___ Relationship ____

A false statement in this application will not prevent the right to receive the benefit unless the false statement was made with the actual intent to deceive or unless it materially affected the acceptance of the risk assumed by the insurer.

GENERAL RISK QUESTIONS

A "YES" answer to Questions 1-13 may trigger an additional Questionnaire. Provide details to "Yes" answers in Details Section.

1) Has Insured plead guilty to or been convicted of a driving while impaired (alcohol, drugs, other) violation, had Driver's License revoked or suspended, or within the last 36 months plead guilty to 3 or more moving violations? ☐ Yes ☐ No

2) Has Insured had life, disability, health, or long-term care insurance declined, rated, modified, issued with an exclusion rider, canceled, rescinded, denied renewal or denied reinstatement, withdrawn or postponed? ☐ Yes ☐ No

3) In the past 5 years, has Insured been unable to work, unable to attend school or unable to perform normal activities for 30 days or more? ☐ Yes ☐ No

4) Has Insured flown other than as a fare paying passenger on a scheduled airline or have intentions to do so within the next 2 years? ☐ Yes ☐ No

5) Has Insured engaged in or intend to engage in the following within the next 24 months? ☐ Yes ☐ No

If Yes, check all that apply:

☐ Cave Exploration	☐ Scuba/Skin Diving	☐ Parachuting/Sky Diving	☐ Rodeo Riding/Horse Racing
☐ Ballooning	☐ Snowmobile Racing	☐ Hang Gliding/Ultralights	☐ Rock/Ice/Mountain Climbing
☐ Boat Racing	☐ Professional Athletics	☐ Motor Sport Events/Racing	☐ Boxing/Mixed Martial Arts
☐ Helicopter Skiing	☐ Base or Bungee Jumping		

6) Has Insured used or is currently using:

☐ Marijuana ☐ Narcotics ☐ Intravenous Drugs ☐ Cocaine ☐ Barbiturates ☐ Hallucinogens ☐ None

7) Has Insured ever been treated for abuse or been advised by a doctor to limit the use of alcohol, any medication, prescribed or not? ☐ Yes ☐ No

If Yes, check all that apply: ☐ Drug Abuse ☐ Alcohol Abuse

8) Does Insured use alcohol, or used any alcoholic beverage? ☐ Yes ☐ No

If Yes, on average, how many alcoholic drinks are consumed per week? ☐ 1-12 ☐ 13-24 ☐ 25-50 ☐ 50 or more

9) Has Insured ever been on parole or probation, pled guilty to or been convicted of a felony or misdemeanor, or awaiting trial for a felony? ☐ Yes ☐ No

10) Does Insured intend to travel or reside outside the U.S. or Canada within the next 2 years? ☐ Yes ☐ No

11) Is Insured a member of, or have you entered into a written agreement to become a member of any branch of the Armed Forces or reserve military unit? ☐ Yes ☐ No

12) Has Insured ever filed for bankruptcy, or have the intention to seek bankruptcy protection within the next 12 months? ☐ Yes ☐ No

If filed, list chapter filed, date, reason and discharge date._____

13) Is Insured a U.S. Citizen or currently have a valid U.S. Permanent resident green card? ☐ Yes ☐ No

If No, provide details including country, type of visa, expiration date_____Time in the U.S.?_____

MEDICAL QUESTIONS

A "YES" answer to Questions 14-21 may trigger an additional Questionnaire. Provide details to "Yes" answers in Details Section.

14) Insured's Height _____ Weight _____ Any weight change greater than 10lbs in past year? ____ Lbs. ☐ Gain ☐ Loss

Reason, check all that apply: ☐ Diet ☐ Exercise ☐ Surgery ☐ Pregnancy ☐ Unknown

15) Has Insured, been diagnosed, received treatment or medical advice by a member of the medical profession or any of the following? Please check ALL that apply: ☐ None

☐ Heart Attack	☐ Chest Pain	☐ Heart Murmur	☐ Asthma/Bronchitis	☐ Hepatitis	☐ High Blood Pressure
☐ High Cholesterol	☐ Emphysema	☐ Sleep Apnea	☐ Sickle Cell Anemia	☐ Cirrhosis	☐ Epstein-Barr Virus
☐ Multiple Sclerosis	☐ Colitis	☐ Memory Loss	☐ Parkinson's Disease	☐ Arthritis	☐ Eating Disorder
☐ Anemia	☐ Crohn's	☐ Stroke/TIA	☐ Huntington's Disease	☐ Porphyria	☐ Alzheimer's Disease
☐ Lyme Disease	☐ Lupus	☐ COPD	☐ Depression/Anxiety	☐ Diabetes	☐ Cancer/Tumor/Polyp
☐ ALS Disease	☐ Chronic Fatigue Syndrome				

16) Other than as indicated above, has Insured, ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder of any of the following? Please check ALL that apply: ☐ None

☐ Heart	☐ Lymph Nodes	☐ Ears/Nose/Throat	☐ Psychological Disorder	☐ Lungs/Respiratory System
☐ Eyes	☐ Malaise	☐ Immune System	☐ Muscles/Bones/Joints	☐ Chronic/Unexplained Fatigue
☐ Blood	☐ Cancer	☐ Liver/Pancreas	☐ Reproductive Organs	☐ Gastrointestinal/Digestive System
☐ Skin	☐ Chronic pain	☐ Kidney/Bladder	☐ Thyroid/Other Glands	
☐ Prostate	☐ Arteries/Veins	☐ Emotional Disorder	☐ Brain/Nervous System	

17) Is Insured currently receiving any treatment or taking any prescription or nonprescription medications / supplements prescribed by a member of the medical profession? ☐ Yes ☐ No

18) Does Insured have any surgery, medical tests, treatment or visits with a health professional scheduled in the next 6 months? ☐ Yes ☐ No

19) Has Insured had any abnormal diagnostic or screening tests or been advised by a member of the medical profession to have any diagnostic test – except those tests related to the HIV (AIDS virus), hospitalization, surgical procedure or treatment that has not been done? ☐ Yes ☐ No

20) Has Insured been diagnosed by a member of the medical profession for AIDS (acquired immune deficiency syndrome)? ☐ Yes ☐ No

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21) If Insured is over age 70 please answer the following questions:

a) Within the last 2 years, have they been unable to participate in normal activities or been confined at home? ☐ Yes ☐ No

b) Does Insured live in a facility or receive in home assistance that provides him or her with personal care? ☐ Yes ☐ No

c) Has Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? ☐ Yes ☐ No

d) Within the last 2 years, has Insured had any falls, or been bed-ridden for 2 weeks or more, or required assistance in walking, eating, bathing, toileting, or dressing? ☐ Yes ☐ No

If additional room is needed in any section, please add blank sheet of paper:

MEDICATION

For Insured, please provide Medication Prescribed and what condition prescribed for: (if None, write None)

Name of Medication	Date Prescribed	Dosage (milligrams etc.)	Reason Prescribed

PHYSICIAN INFORMATION

For Insured, please provide Name and Address of usual medical advisor, Date of and Reason for last visit, Treatment Given, also include any pending medical appointment with any other medical provider: (if None, write None)

DETAILS, SPECIAL REMARKS AND CIRCUMSTANCES

DETAILS (Explain "Yes" answers to General Risk and Medical Questions 1 – 21, except Question 13)

Question#	Explanation or Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

FAMILY HISTORY

Has a parent, sibling or children ever had any conditions listed in questions 15 and 16 in the Medical Questions Section: ☐ Yes ☐ No

Relationship to Proposed Insured	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death
Father			
Mother			
Sibling			
Sibling			

Please add any additional comments, medical/physician information, and/or beneficiaries to expedite processing of application on an additional blank sheet of paper.

AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT

I, the Insured (and Owner, if applicable, signing below), by my signature set forth hereafter:

AGREE to the following:

a) I will comply with all laws and rules of the Constitution and Laws of the Society;
b) I have read the application and all statements and answers as they pertain to me. All Statements and answers in this application are complete and true to the best of my knowledge and belief;
c) The statements and answers in the application are the basis for any policy issued by the Society, and that no information about me will be considered to have been given to the Society unless it is stated in the application, and that I will notify the Society of any changes in the statements or answers given in the application between the time of application and delivery of the policy;
d) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is delivered and accepted while the health of any proposed insured continues to be as represented in this application;
e) No producer has authority to accept risk, pass on insurability, or make, void, waive or change and answer or otherwise modify this application, policy or receipt, or to bind the Society in any way by making any promise or representation which is not set out in writing in this application;
f) $ 0 has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted.

AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, laboratory, pharmacy, pharmacy benefits manager, insurance support organization, government agency, insurance or reinsuring company, MIB, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person having knowledge of me or my health to release all information about me to the Society, its Medical Director, or its reinsurer(s), for underwriting or claims purposes. I further authorize the release of any information obtained to other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required.

The information collected may pertain to symptoms, medical consultations, treatments or prognosis, prescription drugs, pharmaceutical records, surgeries, and hospital confinements which relate to any physical and mental condition, including information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, alcohol or drug use, but excludes psychotherapy notes. If we need those records, we will ask for them on a separate authorization form.

This authorization also includes information relating to any other non-health (non-medical) history information.

I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance.

I understand that after this information is disclosed, the recipient may re-disclose it resulting in the loss of protection under federal rules governing privacy and confidentiality.

I agree that a photographic copy of this authorization will be as valid as the original and that it will be valid for 24 months from the date shown below or the time limit permitted by applicable law in the state where the policy is delivered or issued for delivery if shorter than 24 months. This authorization will survive the Insured's death if it occurs while the authorization is in effect. I know that I or my representative may request a copy of this authorization.

I understand I may revoke this authorization at any time by sending written notice to 1891 Financial Life at 200 N. Martingale Rd., Ste. 405, Schaumburg, IL 60173. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action was taken prior to receipt of notice of revocation.

If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim.

If the law of my state so provides, my authorization may not be revoked during a contestable investigation.

I may refuse to sign this authorization and understand that my refusal to sign will affect my ability to obtain life insurance coverage.

ACKNOWLEDGE receipt of "Notice of Information Practices" and "Consent to Electronic Signature and Electronic Document Delivery".

1891 FINANCIAL LIFE IS LICENSED TO DO BUSINESS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN ANY STATE'S 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.

A false statement in this application will not prevent the right to receive the benefit unless the false statement was made with the actual intent to deceive or unless it materially affected the acceptance of the risk assumed by the insurer.

Signed at_____ on_____.
City State Date

X_____
SIGNATURE OF INSURED
- if age 16 or over, or Parent or Guardian if under age 16 or age of majority required by state where policy is issued for delivery

X_____
SIGNATURE OF OWNER
- if other than Primary Insured

PRODUCER'S REPORT

1) Producer Checklist (Provide details in Field Underwriting Remarks, section below)

a) Did you give the Applicant a copy of the Privacy Notice and other disclosure information..... ☐ Yes ☐ No
b) Are you related to the Insured?..... ☐ Yes ☐ No
c) Was this application taken in person..... ☐ Yes ☐ No
d) Do you know anything not disclosed which might affect the underwriting of this risk? ..... ☐ Yes ☐ No
e) Is there another application currently pending or being submitted to any other life insurance company? ..... ☐ Yes ☐ No
f) Has any Insured applied elsewhere for any insurance coverage within the past 6 months?..... ☐ Yes ☐ No
g) Is replacement of existing insurance involved in this application?..... ☐ Yes ☐ No
If Yes, submit the appropriate replacement forms.
h) Did you ask the Applicant all of the questions on this application? ..... ☐ Yes ☐ No

2) If the Insured is age 0-16, please answer questions below:

a) Number of brothers _____, sisters _____.
Do they all have the same amount of insurance as the Insured? ..... ☐ Yes ☐ No
If amount of insurance differs, explain in Producer's Underwriting Remarks section.
b) If less than 1 year of age, what was the birth weight? _____Lb. _____ Oz.
c) Did you see the Insured?..... ☐ Yes ☐ No
d) Amount of life insurance in force and/or requested on father: $ _____ and mother $ _____.

I certify I have accurately recorded all information given by the Insured and my statements on this Producer's Report are correct to the best of my knowledge.

_____
Date

_____	_____	_____	_____%
Name of Insurance Producer	Signature	Writing No.	Split
_____	_____	_____	_____%
Name of Insurance Producer	Signature	Writing No.	Split

PRODUCER'S UNDERWRITING REMARKS

NOTICES – Must be Given to the Proposed Insured –

NOTICE OF INFORMATION PRACTICES

1891 Financial Life will need to collect information about you in order to issue an insurance policy. You are our most important source of information. We may supplement that information with information from other sources such as medical professionals who have treated you. We may also ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained below under Federal Fair Credit Reporting Notice.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about and receive copies of items of information we collect that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send a written request to 1891 Financial Life at 200 N. Martingale Rd., Ste. 405, Schaumburg, IL 60173.

FAIR CREDIT REPORTING ACT NOTICE

In making this application, it is understood that we may obtain information through an investigative consumer report. An independent source known as a consumer reporting agency will prepare the report. The report typically includes information as to your character, general reputation, personal characteristics, and mode of living. The agency may conduct personal interviews with your family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted in order to get information for the report.

If you write to us within a reasonable period of time after you receive this notice, we will tell you whether or not a report was requested. If a report was requested, we will provide you with the name, address, and telephone number of the consumer reporting agency conducting the report. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect the report and to receive a copy of the report, you may contact the consumer reporting agency directly.

NOTIFICATION REGARDING MIB, Inc. ("MIB")

Information regarding your insurability will be treated as confidential. 1891 Financial Life or its Reinsurer(s), may, however, make a brief report thereon to the MIB, a non-for profit membership organization of life 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 a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of and information it may have in your file by calling (866) 692-6901 or you can go to their website, www.mib.com. 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 Reporting Act. The address of MIB is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

1891 Financial Life, or its Reinsurer(s), may also release information in its files 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.

PRIVACY NOTICE

Protecting your privacy is very important to the 1891 Financial Life.
This notice summarizes the privacy policy and information practices of 1891 Financial Life. We have strict policies and procedures in place to safeguard your personal data. Our employees and agents are required to comply with our established policies and procedures. We maintain physical, electronic, and procedural safeguards to protect your personal information from being accessed by unauthorized persons.

Information we may collect.
We may collect certain nonpublic personal information about you. This allows us to underwrite and administer your insurance coverage, inform you of other programs and benefits that may be of interest to you and comply with legal and regulatory requirements. The information we collect depends on the products or services you request and may include information such as:

- Information we receive from you on an application or other form such as your name, address, age, residence, marital status, social security number, income and assets.
- Information we receive from a consumer-reporting agency, such as credit history.
- Information about your past transactions with us such as the products you have purchased, your contract values, and your payment history.
- Information from outside parties to verify representations made by you such as employment information, medical information, health history, other insurance coverage, or public records.
- General information about you such as your email address, demographic information, avocations, and other personal characteristics.

How we use and disclose your information.
We do not share your information with other organizations except as permitted by law. For example, we may share your information with other individuals or organizations to help underwrite your insurance, process applications or administer claims, help detect fraud or criminal activity, or assist us in providing benefits to you as a part of your membership. We may also share your information with sales agents and independent brokers who are authorized by the Society; to marketing organizations or mailing companies to assist us in communicating with and providing service to you. We may also be required to comply with an information request by a government entity or regulator. If we need to share your nonpublic personal information with an affiliated institution or any third-party non-affiliates, we require that they provide the same level of confidentiality and protection.

We do not sell lists of names and addresses of our members to any vendor for goods or services. Our privacy policy also extends to former members who no longer have coverage with the Society.

We may share personal information such as names, addresses, and Court / Impact Team function photos, with our related fraternal Courts / Impact Teams for fraternal purposes (such as sending you information about Court / Impact Team meetings and events, volunteer activities, the 1891 Financial Life magazine, etc.).

Keeping your information accurate and up-to-date is very important to us. If you determine that any information we have for you is incorrect, please contact us so that it may be corrected. Call: Customer Care (800) 344-6273.

CONTACT US WITH QUESTIONS

If you have any questions about our Privacy Policy or our information practices, you may contact the Privacy Officer at: CCPAREQUEST@1891FinancialLife.com, or (872) 263-2460, or write us at the address below.

1891 Financial Life
Attn: Privacy Officer
200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173
(Updated 9/22)

CONDITIONAL RECEIPT – Must be Given to the Proposed Insured –

This Receipt creates an Agreement to provide temporary life insurance protection according to the Terms and Conditions. This Agreement does not guarantee the Society will issue a life insurance policy or any riders or endorsements thereto. The Society reserves the right to terminate this agreement at any time.

TERMS AND CONDITIONS

COVERAGE DATES

Coverage under this Agreement begins on the date of the Receipt so long as the corresponding Application is signed and dated on the same date.

Coverage under this Agreement ends on the earliest of a) the date the insurance applied for is issued or declined, b) the date the Society mails notice of termination to the Owner or refunds the initial premium, c) 90 calendar days from the date of the Receipt.

AMOUNT OF COVERAGE

If money has been accepted by the Society as full initial premium for an Application for life insurance and death occurs while this Agreement is in effect, the Society will pay to the beneficiary designated in the Application the lesser of a) the amount of the base death benefit applied for in the Application with respect to said Insured, or b) $100,000. This total benefit limit applies to the Insured under this and any other pending Application(s) to the Society.

LIMITATIONS

There is no coverage under this Agreement:

a) if the Insured is older than age 70;
b) if the Insured is not insurable as applied for (Not Applicable in KS);
c) if the insurance applied for is at or above substandard Table 3 (Not Applicable in KS);
d) for any riders or additional benefits, if any, for which you have applied;
e) for 1035 Exchanges or Transfers; or
f) unless amount paid with the application equals the full modal premium and is honored for payment when first presented.

Fraud or material misrepresentation in the Application invalidates this Agreement and the Society's only liability is for refund of any premium payment made.

If Insured dies by suicide, whether sane or insane, the Society's liability under this Agreement is limited to a refund of the premium payment made.

No one is authorized to waive or modify any of the provisions of this Agreement.

Life Plan _____ **Premium Paid $** _____

All premium checks must be payable to 1891 Financial Life.
Do not make check payable to the Insurance Producer or leave the payee blank.

I acknowledge that the terms and conditions have been explained to me by the Insurance Producer and I have read, understand and accept them.

I also understand that no coverage under the policy applied for will become effective unless all other conditions for coverage have been met except as provided in this agreement.

_____ _____
Date Signature of Owner

_____ _____
Date Signature of Insurance Producer

If no Insurance Producer is present, simply mail application along with your payment to:
1891 Financial Life, Attn: New Business
200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173

QUESTIONS? Please call: (800) 344-6273

200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173
847-342-4500
info@1891FinancialLife.com
www.1891FinancialLife.com

CERTIFICATE PAYMENT OPTIONS

Certificate Number: _____ **Insured:** _____

Payor's Full Name: _____

Address / Apt. No: _____

City: _____ State: _____ ZIP:_____

Primary Phone No: _____ Email: _____

Premium Amount: $_____ **Payment Type:** ☐ Electronic Funds Transfer **OR** ☐ Debit/Credit Card

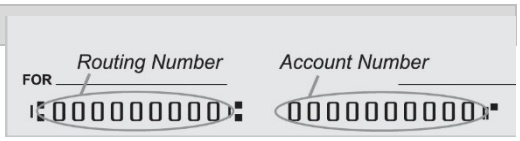
Payment Frequency ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Single Premium

Premium payments will be drafted within seven (7) days after application approval.

Dates NOT available for premium payment: 29th – 30th – 31st

The premium will be automatically drafted each billing cycle. No notice will be sent when drafted.

Electronic Funds Transfer (EFT)



Please Attach a Copy of a Voided Check to Verify Account Number Accuracy.

Account Type: ☐ Checking ☐ Savings

_____ _____ _____

Financial Institution | Bank Routing Number | Account Number

Debit/Credit Card

_____ _____ _____ _____

Name on the Card | Account Number | Expiration Date | CVV/CSV

Authorization

I (we) request and authorize 1891 Financial Life ("the Organization") to obtain premium payment of amounts becoming due the Organization or amounts as scheduled and requested by the policyowner/payor by initiating charges to my (our) account in the form of checks, drafts, share drafts, or electronic debit entries, credit card and I (we) request and authorize the financial institution named above to accept and honor the same and charge the same to my (our) account. This Authorization will remain in effect until I (we) notify the Organization or financial institution in writing to terminate and the Organization or the financial institution has a reasonable time to act on the termination. This Authorization will become effective only upon acceptance by the Organization of approval of this life insurance policy. The Organization address 200 N. Martingale Rd., Ste. 405, Schaumburg, IL 60173. 1891 Financial Life reserves the right to discontinue this program at any time.

Payment Terms and Conditions

The Organization will have no liability under this application unless and until: (a) it has been received and approved by the Organization; (b) the Certificate has been issued and delivered to the Certificate Owner; (c) the first premium has been paid to and accepted by the Organization or authorization to draft first payment has been given and the financial institution has not notified the Organization that the draft will not be honored; and (d) at the time of delivery and payment, the facts concerning the insurability of the Proposed Insured are as stated in this application. The Proposed Insured, Owner, or Payor will not receive any premium notices.

_____ _____

ACCOUNT OWNER SIGNATURE | DATE

200 N. Martingale Rd., Ste. 405
Schaumburg, IL 60173
847-342-4500
info@1891FinancialLife.com
www.1891FinancialLife.com

1891 FINANCIAL LIFE MEMBERSHIP

You are joining a unique member-owned organization. You are more than a customer, you become a member of our Organization. You have a set of member benefits that also includes the opportunity help build stronger communities by supporting service projects that reflect common shared values.

TO BE COMPLETED BY THE PROPOSED INSURED

I am age 16 or older and am applying for membership with 1891 Financial Life.

_____ _____ _____
First Name Middle Name Last Name

_____ _____ _____ _____
Address / Apartment Number City State Zip

Primary Phone _____ _____ Alternate Phone _____ _____
Number Type Number Type

_____ _____ Gender ☐ M ☐ F
Email Address Date of Birth

PUBLICATIONS

Members receive a quarterly newsletter with messages from the CEO and Outreach, or they can view an e-magazine on our website with expanded outreach coverage like scholarship winners, member events and photos, and articles about life insurance and finance.

SURVEY

For survey purposes please select from one of the following:

☐ I am Catholic
☐ I am a spouse of a Catholic
☐ I am not Catholic

MISSION

1891 Financial Life is a community-based insurance organization that offers products and member benefits that assist individuals and their families in achieving financial security, while helping to build stronger communities by supporting service projects that reflect common shared values.

I support the purposes of 1891 Financial Life as described in the Articles of Incorporation as well as its Mission and will comply with the Bylaws of 1891 Financial Life. I also verify that the information I provided is true and correct.

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CHARITABLE GIVING RIDER
APPLICATION

1) Insured

First Name: _____ Middle: _____ Last: _____

Phone: _____ Email:_____

☐ I would like my donation to be anonymous.

2) Qualified Charitable Organization[1]

Name: _____

Address: _____

City: _____ State: _____ ZIP:_____

Phone: _____ 501(c)(3) Tax ID Number:_____

Percent of Benefit to be payable to the Qualified Charitable Organization (QCO): _____%

3) Signature of Owner

I understand the beneficiary designation(s) noted here is final unless revoked by a future beneficiary change form.

First Name: _____ Middle: _____ Last: _____

Phone: _____ Email:_____

Signature of Owner: _____ Date: _____

FOR HOME OFFICE USE ONLY

Certificate No.: _____ This request is accepted on MM/DD/YYYY: _____

By: _____

On Behalf of 1891 Financial Life

REMARKS:

ABOUT CHARITABLE GIVING RIDER

Death benefits are payable under the policy to which this rider is attached, the benefit paid will equal to the sum of:

a) A minimum of 1% of the contract's at-issue "Benefit Amount", or its adjusted benefit amount in the event of a subsequent reduction in the at-issue benefit amount after any loan balance is deducted; and will not include any dividend amounts or rider benefits payable. The death benefit payable to the beneficiary(ies) of the contract will be reduced by this amount.
b) 1891 Financial Life will match the amount calculated in (a).
c) The sum of (a) and (b) will not exceed $2,500.

[1]A qualified charitable organization ("QCO") is defined as an organization which is organized and operated exclusively for tax-exempt purposes and meets the requirements set forth under section 501(c)(3) of the Internal Revenue Code and supports the mission and purpose of 1891 Financial Life as described in the Articles of Incorporation. 1891 Financial Life reserves the right to reject any QCO that does not support our mission and purpose[2].

[2]The purposes of the Society are to: promote friendship, unity and true Catholic charity among its members, foster fraternal and benevolent activities, further the progress of the Catholic Church, encourage patriotism and loyalty to the United States of America, and provide death, disability and other benefits, rights and privileges, as authorized by these Articles of Incorporation and Bylaws and in accordance with the laws of Illinois.

1891 financial life

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IMPORTANT NOTICE REQUIRED BY LAW
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the insurance producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1) Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ..... ☐ Yes ☐ No

2) Are you considering using funds from your existing certificate or contracts to pay premiums due on the new policy or contract? ..... ☐ Yes ☐ No

If you answered “yes” to either of the above questions, list each existing certificate or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	Insurer Name	Contract or Policy #	Insured or Annuitant	Replaced (R) or Financing (F)
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____

Make sure you know the facts. Contact your existing insurer or its agent for information about the existing policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

*** Note important statement on page 3.**

The existing policy or contract is being replaced because: _____

_____

I do not wish this notice to be read aloud to me: _____
(Applicants must initial only if they do not want the notice read aloud)

A replacement may not be in your best interest, or your decision could be a good one.

You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the insurer or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract.

This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS

1) Are they affordable?
2) Could they change?
3) You're older, are premiums higher for the proposed new policy?
4) How long will you have to pay premiums on the new policy? … on the existing policy?

POLICY VALUES

1) New policies usually take longer to build cash values and to pay dividends.
2) Acquisition costs for the existing policy may have been paid, you will incur costs for the new one.
3) What surrender charges do the policies have?
4) What expense and sales charges will you pay on the new policy?
5) Does the new policy provide more insurance coverage?

INSURABILITY

1) If your health has changed since you bought your existing policy, the new one could cost you more, or you could be turned down.
2) You may need a medical exam for a new policy.
3) Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
4) Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE EXISTING POLICY AS WELL AS THE NEW POLICY

1) How are premiums for both policies being paid?
2) How will the premiums on your existing policy be affected?
3) Will a loan be deducted from death benefits?
4) What values from the existing policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT

1) Will you pay surrender charges on your existing contract?
2) What are the interest rate guarantees for the new contract?
3) Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

1) What are the tax consequences of buying the new policy? Is this a tax-free exchange? (See your tax advisor)
2) Is there a benefit from favorable "grandfathered" treatment of the existing policy under the federal tax code?
3) Will the existing insurer be willing to modify the existing policy?
4) How does the quality and financial stability of the new insurer compare with your existing insurer?

In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract owner in printed form no later than at the time of policy or contract delivery.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____	_____	_____
Applicant's Signature	Printed Name	Date
_____	_____	_____
Insurance Producer's Signature	Printed Name	Date

I certify that this form was given to and completed by _____ Applicant prior to taking an application and that I am leaving a signed copy for the applicant.

_____	_____
Insurance Producer's Signature	Date

Did you use only company approved sales material? ☐ Yes ☐ No

_____	_____
Insurance Producer's Signature	Date

*** CAUTION: If after studying the information made available to you, you decided to replace your existing life insurance or annuity with our policy or annuity contract, you are urged not to take action to terminate or alter your existing coverage or annuity (ies) until after you have been issued the new policy or annuity contract, examined it and found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage or annuity (ies) and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or be able to purchase it only at substantially higher rates.**

DEFINITIONS

PREMIUMS. Premiums are the payments you make in exchange for an insurance policy or annuity contract. They are unlike deposits in a savings or investment program, because if you drop the policy or contract, you might get back less than you paid in.

CASH SURRENDER VALUE. This is the amount of money you can get in cash if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and the loan value. Not all policies have cash surrender values.

LAPSE. A life insurance policy may lapse when you do not pay the premiums within the grace period. If you had a cash surrender value, the insurer might change your policy to as much extended term insurance or paid-up insurance as the cash surrender value will buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the premiums.

SURRENDER. You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. Whenever a policy has a cash surrender value, you can get it in cash if you return the policy to the company with a written request. Most insurers will also let you exchange the cash value of the policy for paid-up or extended term insurance.

CONVERT TO PAID-UP INSURANCE. This means you use your cash surrender value to change your insurance to a paid-up policy with the same insurer. The death benefit generally will be lower than under the old policy, but you will not have to pay any more premiums.

PLACE ON EXTENDED TERM. This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefit will be the same as before. However, you will only be covered for a specified period of time stated in the policy.

BORROW POLICY LOAN VALUES. If your life insurance policy has a cash surrender value, you can almost always borrow all or part of it from the insurer. Interest will be charged according to the terms of the policy, and if the loan with unpaid interest ever exceeds the cash surrender value, your policy will be surrendered. If you die, the amount of the loan and any unpaid interest due will be subtracted from the death benefits.

EVIDENCE OF INSURABILITY. This means proof that you are an acceptable risk. You have to meet the insurer's standards regarding age, health, occupation, etc., to be eligible for coverage.

INCONTESTABLE CLAUSE. This says that after two years, depending on the policy or insurer, the life insurer will not resist a claim because you made a false or incomplete statement when you applied for the policy. For the early years, though, if there are wrong answers on the application and the insurer finds out about them, the insurer can deny a claim as if the policy had never existed.

SUICIDE CLAUSE. This says that if you commit suicide after being insured for less than two years, depending on the policy and insurer, your beneficiaries will receive only a refund of the premiums that were paid.

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REPLACEMENT POLICY COMPARISON

	EXISTING POLICY A	EXISTING POLICY B	PROPOSED CERTIFICATE
Company Name			
Product Name			
Policy Number			
Issue Date			n/a
Underwriting Class			n/a
Face Amount			
Estimated Current Death Benefit (If other than face amount shown above)			
Premium Annualized			
Type of Product			
Policy Fee Charge (front end load)			
As a % of Premium			
Total Cash Value (Whole) or Total Accumulated Value (Variable or UL)			
Surrender Charge Period			
Estimated Surrender Charges for Existing Policy			
Loan Interest Rate			n/a
Existing Policy Loan Amount			
Is the Replacement a 1035 Exchange?			n/a
Is there a gain in the existing policy? (If yes, please provide amount)			n/a

The PRIMARY reason for purchasing the new life insurance certificate is (be specific). _____

_____

The existing life insurance policy cannot meet the owner's objectives because (be specific). _____

_____

Insurance Producer's Certification. I certify that I have discussed the advantages and disadvantages of replacement with the owner, and that I have determined replacement is appropriate for the owner.

_____ _____ _____

Insurance Producer's Signature | Insurance Producer's Printed Name | Date

Owner's Acknowledgement. I have reviewed and understand the potential advantages and disadvantages of replacing my current policy and I wish to proceed with replacing my current policy. If this replacement involves a loan or partial surrender from an existing policy, this will result in a reduction in values in my existing policy. In addition, with respect to life insurance policies, loans or partial surrenders may result in additional payments being required to keep my existing policy in force. Policy loans also reduce the available death benefit and incur interest charges.

_____ _____ _____ _____

Owner's Signature | Owner's Printed Name | Date | Date of Birth