Application for Life Insurance and Membership to SPJST and Lodge _____

APPLICATION PART 1

1. Proposed Insured: First Name	**Middle Name**	**Last Name**		
Date of Birth	**Age:**	**Sex:**	**DL # and State:**	**Social Security #:**
Place of Birth:	**Citizen of USA:**	**If legal resident; provide residency number and expiration date:**		
Home Address				
Billing Address, if different from home address				
Contact numbers: Cell	**Home**	**Email address:**		
Marital Status	**Maiden Name**	**Occupation**	**Employer:**	
Name of Spouse				

APPLICATION PART 2 **Family Value Universal Life**

Face Amount $_____ **Death Benefit Option: [** ☐ A (Level) or ☐ B (Increasing)]

Risk Classification: [☐Preferred Non-Nicotine ☐Standard Non-Nicotine ☐Standard Nicotine]

Riders: [☐Accidental Death ☐Waiver of Cost of Insurance ☐Guaranteed Insurability]

Planned Premium: $_____

Method of Payment: [☐Monthly ACH ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Single Premium]

Is this to increase an existing SPJST UL Certificate? If yes, provide SPJST certificate number _____

Term Life Products

Plan of Insurance: Face Amount: _____

[☐ **10 Year Term**

☐ **15 Year Term**

☐ **20 Year Term**

☐ **30 Year Term**

☐ **Juvenile JT21]**

Risk Classification: [☐Preferred Plus Non-Nicotine ☐Preferred Non-Nicotine ☐Standard Non-Nicotine ☐Preferred Nicotine ☐Standard Nicotine]

Rider: [☐Accidental Death ☐Waiver of Premium]

Total Submitted Premium $_____

Method of Payment: : [☐ Monthly ACH ☐ Quarterly ☐Semi-Annual ☐Annual]

Permanent Life Products: Face Amount: _____

Plan of Insurance: [☐ **Whole Life**
☐ **10-Pay Life**
☐ **20-Pay Life**
☐ **Paid up at 65**
☐ **Single Premium]**

Risk Classification:[☐ **Preferred Non-Nicotine**
☐ **Non-Nicotine**
☐ **Nicotine]**

Rider: [☐ **Accidental Life**
☐**Waiver of Premium**
☐**Guaranteed Insurability]**

Total Submitted Premium: $_____ **APL: ☐ Yes or ☐ No**

Method of Payment: [☐**Monthly ACH** ☐**Quarterly** ☐**Semi-Annual** ☐**Annual** ☐**Single Premium]**

Section A – Individual Beneficiary Information F

or ***Trusts, please forward copy with application***

Use additional pages as needed. Each beneficiary category (primary, contingent, or tertiary) should equal 100% of the allocation of insurance proceeds. A beneficiary category can include any grouping of individuals, and/or trusts, and/or estates to determine the 100% allocation.

Individual(s) Designated as Beneficiary(ies) ☐ **Per Stirpes** ☐ **Per Capita** **If no selection made "PER STIRPES" designation will be applied**

Beneficiary: ☐Primary ☐Contingent ☐Tertiary Full Name_____ Relationship _____ Beneficiary Percent of Insurance _____% Date of Birth (mm/dd/yyyy) _____/_____/_____ Social Security Number_____ Address_____ City_____ State_____ Zip_____-_____ Home Phone Number (_____)_____-_____ Cell Phone Number (_____)_____-_____ Email Address_____	Beneficiary: ☐Primary ☐Contingent ☐Tertiary Full Name_____ Relationship _____ Beneficiary Percent of Insurance _____% Date of Birth (mm/dd/yyyy) _____/_____/_____ Social Security Number_____ Address_____ City_____ State_____ Zip_____-_____ Home Phone Number (_____)_____-_____ Cell Phone Number (_____)_____-_____ Email Address_____
Beneficiary: ☐Primary ☐Contingent ☐Tertiary Full Name_____ Relationship _____ Beneficiary Percent of Insurance _____% Date of Birth (mm/dd/yyyy) _____/_____/_____ Social Security Number_____ Address_____ City_____ State_____ Zip_____-_____ Home Phone Number (_____)_____-_____ Cell Phone Number (_____)_____-_____ Email Address_____	Beneficiary: ☐Primary ☐Contingent ☐Tertiary Full Name_____ Relationship _____ Beneficiary Percent of Insurance _____% Date of Birth (mm/dd/yyyy) _____/_____/_____ Social Security Number_____ Address_____ City_____ State_____ Zip_____-_____ Home Phone Number (_____)_____-_____ Cell Phone Number (_____)_____-_____ Email Address_____
Beneficiary: ☐Primary ☐Contingent ☐Tertiary Full Name_____ Relationship _____ Beneficiary Percent of Insurance _____% Date of Birth (mm/dd/yyyy) _____/_____/_____ Social Security Number_____ Address_____ City_____ State_____ Zip_____-_____ Home Phone Number (_____)_____-_____ Cell Phone Number (_____)_____-_____ Email Address_____	Beneficiary: ☐Primary ☐Contingent ☐Tertiary Full Name_____ Relationship _____ Beneficiary Percent of Insurance _____% Date of Birth (mm/dd/yyyy) _____/_____/_____ Social Security Number_____ Address_____ City_____ State_____ Zip_____-_____ Home Phone Number (_____)_____-_____ Cell Phone Number (_____)_____-_____ Email Address_____

Section B – General Risk Questions – Any questions answered "yes" please explain in detail section

In the past 5 years, has the Proposed Insured

01. flown as a pilot, student pilot or crew member of any aircraft, have intention to do so?..... ☐Yes ☐No

02. engaged in parachuting, scuba diving, racing or other hazardous sport or intend to do so? ..... ☐Yes ☐No

03. had an application for life or health insurance declined, postponed, rated, or modified? ..... ☐Yes ☐No

04. had your driver's license suspended or revoked, or have you been convicted of 2 or more moving violations or accidents?..... ☐Yes ☐No

05. been convicted of, or plead guilty or no contest to DUI or DWI, or under the influence of drugs? ..... ☐Yes ☐No

06. been on parole or probation, charged with a felony or misdemeanor, or awaiting trial for a felony? ..... ☐Yes ☐No

07. used or is now currently using illegal drugs, or been treated for drug or alcohol abuse or been advised by a doctor to limit the use of alcohol or any medication, prescribed or not?..... ☐Yes ☐No

08. Alcohol: Does applicant consume alcohol? ..... ☐Yes ☐No
If yes, provide: TYPE:_____ number of drinks _____per day/week

09. A. Used any nicotine products (including vape, e-cigs, nicotine gum or lozenges, nicotine patches,)?..... ☐Yes ☐No
B. If no, how long ago did you use nicotine products, select only one:
☐ never ☐ 12 months ☐ 24 months ☐ 36 months

10. Does the Proposed Insured intend to travel or reside outside the United States for longer a 2 week period?..... ☐Yes ☐No

11. Do you have existing life insurance or annuity contracts in force with SPJST or any other company?..... ☐Yes ☐No
If yes, List name of company:_____ Amount of coverage_____
Is replacement of existing insurance involved in this application? ..... ☐Yes ☐No

Details for questions 1-11:_____

_____

_____

Section C – Family History

Father: If alive: Age_____ OR Age at death _____ Cause of death_____

Mother: If alive: Age _____ OR Age at death _____ Cause of death_____

Siblings: # alive _____ AND Age Range _____

deceased_____ AND Cause of Death(s)_____

12. What is your current height and weight: _____feet _____inches _____pounds

13. Weight change in past 12 months? _____pounds ☐ gain ☐ loss 14. Cause of weight gain/loss:_____

15.Name of Clinic/Physician: _____ Phone Number: _____

Address:_____

Date of Last visit:_____ Reason:_____

SECTION D – GENERAL HEALTH QUESTIONS – Explain "Yes" in Details

16. Has the Proposed Insured ever had, been told they had, or received treatment or medication or advice for any of the following conditions/diseases/disorders:

	Condition/Disease/Disorder	Yes	No		Condition/Disease/Disorder	Yes	No		Condition/Disease/Disorder	Yes	No
1	Abnormal Test Results			18	Depression/Anxiety			35	Neuromuscular		
2	ADD/ADHD			19	Development Delay			36	Palpitations/Arrhythmia		
3	Any Diagnostic Test or Surgery not yet completed or results that are unknown			20	Diabetes			37	Pancreas		
4	Alzheimer/Dementia			21	Epilepsy/Seizure/Convulsion			38	Paralysis		
5	Asthma			22	Eyes/Ears/Nose/Throat			39	Parkinson's/Tremors		
6	Autism/Asperger's			23	Gastrointestinal			40	Peripheral Vascular Disease		
7	Blood Disorder/Anemia			24	Heart/Blood Vessel Disease			41	Pituitary		
8	Bone/Joint/Muscle/Arthritis			25	High Blood Pressure			42	Prostate		
9	Bronchitis			26	Human Immunodeficiency virus (HIV) or Aids			43	Reproductive System		
10	Cancer/Tumor/Mass			27	Kidney/Bladder			44	Shortness of Breath		
11	Cerebral Palsy			28	Liver/Cirrhosis/Hepatitis			45	Skin		
12	Cerebrovascular Disease/Stroke/TIA			29	Lung/Respiratory			46	Sleep Apnea		
13	Chronic Pain/Disability			30	Lupus (SLE)/Scleroderma			47	Suicide Attempt		
14	Clotting Disorder			31	Mental/Nervous Illness			48	Thyroid/Glandular		
15	Colitis/Ileitis			32	Multiple Sclerosis			49	Tuberculosis		
16	COPD/Emphysema			33	Muscular Dystrophy			50	Ulcer/Gastritis		
17	Coronary Artery Disease (CAD)/Heart Attack			34	Neurologic System/Brain			51	Other not mentioned		

DETAILS for any "Yes" in questions 16 **(Attach additional page if needed – Applicant must sign attachment)**

Illness Date of diagnosis Treatment (medication/surgery) Doctors and Hospitals

_____

_____

_____

_____

_____

17. List names of all medications you are currently prescribed, that are not listed above:

_____

_____

_____

_____

Section E – TO BE COMPLETED ON OWNER (Designate Owner if other than proposed insured)

18. Owner (If business, list authorized contact person.) _____

19 Relationship:_____

20. Owner Address (if different than Proposed Insured: Street:_____

City:_____ State:_____ Zip:_____

21. Social Security number or if business Tax ID: _____

22. Sex: ☐Male ☐Female 23. Age last Birthday _____ 24. Date of Birth (mm/dd/yyyy): _____/_____/_____

25. If owner is a business: ☐KEY MAN ☐BUY/SELL AGREEMENT Business name:_____

26. If juvenile certificate, should insured become the owner when of legal age? ☐Yes ☐No

27. Owners Employment: Job title:_____ How long there?_____

Employer Name:_____ City and State_____

Work phone number:_____ Home Phone number:_____

28. If juvenile, life insurance in force on parent: Name of company_____ Amount_____

Section F – SIGNATURES OF AUTHORIZATION

SPJST may release information to the MIB, LLC ("MIB") pursuant to this notice. I have read the questions and answers written in this application, and to the best of my knowledge and belief, they are true and correct and complete. I authorize the release of medical or non-medical information to SPJST from: any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, pharmacy benefit manager, insurance company, MIB, LLC, ("MIB") or other organization, institution, or person which has any knowledge of me, or my health, to SPJST or its reinsurers. I hereby authorize SPJST to use one of its approved vendors to check my usage of prescription medication. I understand that a telephone interview may be conducted to verify the application.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of the providing organization in writing at the address shown on this application. I understand that I am entitled to a copy of this authorization. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that the insurance applied for shall be subject to the conditions and provisions of the contract of insurance and shall not be in force until the application is accepted and the contract of insurance issued by SPJST.

I hereby apply for membership in SPJST. If accepted, I agree to abide by the Articles of Incorporation and the By-Laws of SPJST and the rules and regulations of said Lodge, all as the same now exist or are hereafter amended. I further agree to pay the required membership dues as requested. I further agree, for myself and my beneficiary(ies), to abide by said By-Laws.

Each of the undersigned declares that the Proposed Insured is eligible for membership under the rules set forth in the Articles of Incorporation and By-Laws of SPJST. I also acknowledge receipt of the NOTICE TO APPLICANT.

_____ _____

Signature of Sales Agent Date Signature of Proposed Insured Date

_____ _____

Signature of Owner (if other than proposed insured) Date Signature of Parent, if Parent Not Purchaser (if juvenile application) Date

---

SPJST LIFE ILLUSTRATION CERTIFICATION

☐ I certify that I did present an illustration to the proposed insured/owner(s) at the time of application.

☐ I certify that I did not present an illustration to the proposed insured/owner(s) at the time of the application

_____

Signature of Sales Agent Date

☐ I acknowledge that I received an illustration at the time I applied for my certificate.

☐ I acknowledge that I did not receive an illustration at the time I applied for my certificate. I understand that an illustration conforming to the certificate as issued will be provided to me no later than at the time the certificate is delivered.

_____ _____

Signature of Owner Date Signature of Proposed Insured Date

Sales Agent's Report: Sales Agent _____ AGT#_____Phone (_____)_____-_____Email_____

1. What other sales agent receives commission on this application?_____ What percent?_____
2. Does the Proposed Insured wish to receive the newspaper (*Vestnik)?* ☐Yes ☐No ☐Mail ☐Email _____

HIPAA Compliant Authorization To Release Confidential Medical Information

Records and Information obtained will be disclosed to SPJST Fraternal Life Insurance, PO Box 100, Temple, TX 76503; ATTN: Underwriting

I authorize any and all medical practitioners, licensed physicians, pharmacists, pharmacy benefits managers, hospitals, clinics, nurses, or records custodians, other insurers to which the proposed insured has applied or may apply, reinsurers, or other medically related facilities, health clearing houses, MIB, LLC, ("MIB") or persons who perform business, professional, or insurance tasks for them, consumer reporting agency; to release

Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

to

SPJST Fraternal Life Insurance.

The purpose of this disclosure is to evaluate my application for insurance. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. **Complete medical records are to be disclosed.**

Applicants Name:_____
First Middle Last

Other Names Used: (Maiden) _____

Date of Birth: _____

Covering the period of health care from: _____to _____

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may become subject to further disclosure by the insurance company. For example, the insurance company may be required to provide it to MIB LLC, ("MIB") an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization (HIPAA 1996). This Authorization will expire in six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting in writing to SPJST at the address listed above. A photocopy of this original will be treated in the same manner as the original.
I understand that if I refuse to sign this authorization to release my complete medical records, SPJST will be unable to gather information needed to determine making an eligibility, underwriting and risk rating decision.
I authorize SPJST Fraternal Life Insurance, or its reinsurers, to make a brief report of my personal health information to MIB.

*HIPAA provides an exception to this for the purposes of underwriting that insurance companies may condition insurance enrollment or eligibility on whether the individual signs the authorization.

Signature of Applicant:_____ Date:_____

Or Parent if the applicant is a minor:_____ Relationship:_____

SPJST
Consumer Authorization for Direct Payment Via ACH (ACH DEBIT)

Here's How ACH Direct Payments Work:
Direct payment via ACH is the transfer of funds from a consumer account for the purpose of making a payment. You authorize regularly scheduled charges to your checking or savings account. You will be charged the amount indicated on the Authorization section of this form. The charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

What are its advantages?

1. SPJST prepares the automated clearing house (ACH) debit for your premiums, loan payments, annuity payments, or any other type of payments as they become due - you do nothing.
2. An accidental lapse of your policy is prevented, since you did not need to mail us your premiums.
3. All payments are made on time.
4. You save postage by not having to mail us your checks.

Can I pay for several certificates or loans on one ACH?
Yes. One ACH debit will pay for all SPJST life or annuity certificates and loan payments.

How am I protected?
SPJST guarantees that we will draw ACH debits only as authorized by you. If we do draw an ACH in error, we will, upon notice of the error, make the proper corrections and advise your bank that it was our mistake.

Can I make monthly annuity contributions by ACH?
Yes. Many members make annuity deposits automatically to SPJST each month.

How do I increase the deduction?
When you buy additional certificates from us or want to increase your payments, we request that you complete a new Authorization form.

What if I change banks?
Notify us in writing or telephone toll free, and we will send you a new authorization card to complete and sign or you can complete a new form on our website, www.spjst.org. Return the signed form to us, along with a voided check, just as you did when you first authorized this plan.

Can I cancel this plan?
Yes! At any time you wish. Simply notify us in writing at PO Box 100, Temple, TX 76503 and we will stop the plan. However, certain certificates that have not authorized ACH debits will not be billed on a monthly basis but will instead require quarterly payments.

How do I start this plan?

1. Complete the Authorization side of this form.
2. Fill in the bank name and address.
3. Fill in the number assigned to your checking account and the routing number.
4. Fill in the depositor's name(s) as they appear on the bank's records.
5. If you want to draft a specific day, please so indicate where provided. Some limitations apply.
6. Return the entire authorization form to us, along with a voided check from the bank account on which the ACH debits are to be drawn.
7. Sign and date the card. Use signature(s) as it (they) appear(s) on your (joint) bank account.
8. Return the form to us in the envelope provided or mail to: SPJST, Attn: Financial Secretary's Department, PO Box 100, Temple, TX 76503.
9. SPJST will do the rest.

Attach Voided Check Here.

ACH Debit - revised 7/27/2015

AUTHORIZATION

I (We) hereby authorize SPJST to electronically debit my (our) account as follows:

☐ **Checking Account** ☐ **Savings Account** (select one) at the financial institution named below ("DEPOSITORY"). Please note that Savings accounts have restrictions based on federal banking laws as to the number of debits that may be activated in a given month. Please check with your bank regarding debiting your savings account. I (We) agree that ACH transactions I (we) authorize comply with all applicable laws.

Name of Bank Account Owner			
Address	City	State	Zip Code
Name of Joint Bank Account Owner			
Address, if different than above	City	State	Zip Code
Full Name of Bank - DEPOSITORY	Routing Number	Bank Account Number	

Certificate/Loan No.	Premium/Loan Payment Amt.	Date (1 - 28)	Frequency - Monthly (M); Quarterly (Q); Semi-Annual (S); Annual (A)
Total ACH Debit			

I (We) further agree that:

1. SPJST's rights in respect to each such ACH transaction shall be the same as if it were a check payable to SPJST and signed personally by me (us).
2. For new business initial payments, I (we) authorize SPJST to make an immediate ACH debit from the bank account listed above upon receipt of this Authorization.
3. ACH transaction(s) will be debited from the specified account on or about the date you select for premium, annuity and certificate loan payments unless that day falls on a weekend or holiday. If the scheduled date falls on the weekend or on a holiday, SPJST reserves the right to debit the account on the nearest business day before the scheduled date. If I (we) have selected the ACH transaction to occur on the 29th, 30th, or 31st day of the month, SPJST will make the draw on or before the 28th day of the month. If no day is selected, SPJST will use the earliest issue date of a certificate listed. Allow two to three days for the movement of funds. All mortgage loan payments are debited on the first business day of the month.
4. This authorization will remain in effect until I (we) notify SPJST in writing at PO Box 100, Temple, TX 76503 ("HOME OFFICE") that I (we) wish to revoke this authorization. I (we) understand that SPJST requires at least three (3) business days prior written notice in order to cancel this authorization.
5. If any such ACH is dishonored, whether with or without cause and whether intentionally or inadvertently, SPJST shall have no liability whatsoever even if such dishonor results in the forfeiture of insurance or delinquent loan payment.
6. SPJST may revoke the privilege of paying premium(s) or loan payment(s) under this Authorization if any payment is dishonored. If such privilege is revoked, an alternate payment mode acceptable to SPJST will be used to remit the premiums needed to keep the certificates / loans in force and current.
7. **A service fee of $25.00 may be assessed for each dishonored payment.**
8. Any requirement for giving notice of premiums or payments due shall be waived so long as this ACH form is in effect for the payment of premiums; but no payment shall be deemed to have been made unless and until SPJST receives actual payment at its HOME OFFICE. Use of the ACH form shall in no way alter or amend the provisions of the certificates as to premium payment or loans as to loan payments. Requests by me (us) that such ACH transaction(s) be drawn on other than the premium due date does not alter that due date and SPJST in no way waives or modifies such due date or the grace period provisions in connection therewith.
9. ACH transactions drawn under this Authorization for loan repayments, upon being charged to my (our) account by the bank, shall be my (our) receipt for the payment as designated. Should any ACH transaction not be honored by said bank upon presentation, then it is understood that such payment shall be charged back to the certificate(s) or loan(s).
10. I have attached a voided check or a letter from the bank, on letterhead, verifying ABA and account number, that is signed by a bank officer.
11. Changes or modifications to bank account information will require new documentation. However, additional premium that may be required in order to keep the certificate current may be drawn from your account provided we notify you at least 10 days prior to the payment being collected.
12. This authorization can be terminated by SPJST upon 30 days written notice.

Dated: _____

SIGNED:

_____ _____

Bank Account Owner Joint Bank Account Owner

ACH Debit - revised 7/27/2015

-If Applicant Has ANY Existing Life Insurance or Annuity Contracts, This Page Must Be Completed

SPJST
PO Box 100 • Temple, TX 76503 • (800) 727-7578

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES
This document must be signed by the Applicant and the 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 policies 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 policy 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:

	INSUROR NAME & ADDRESS	**CONTRACT OR POLICY NUMBER**	**INSURED OR ANNUITANT NAME**	**REPLACED (R) OR FINANCING (F)**
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old 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.

The existing policy or contract is being replaced because: _____

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

_____ _____
Proposed Insured's Signature Date

_____ _____
Sales Agent's Signature Date

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

— Return to Home Office —

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 company 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 will 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: Are they affordable?
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums for the new policy?
How long will you have to pay premiums for the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

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

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor).
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

— Return to Home Office —

NOTICE TO APPLICANT

Federal law requires that notice of investigation be given to persons applying for insurance

In making this application for insurance to SPJST, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confidential, SPJST, or its reinsurers may, however, make a brief report thereon to MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. 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 in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 or go to its website at www.mib.com to request disclosure online. 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's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. SPJST, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, may be obtained on its website at www.mib.com

CONDITIONAL RECEIPT

Unless each and every condition specified below is fulfilled exactly, no insurance will become effective prior to delivery of the certificate of insurance. No agent of SPJST Fraternal Life Insurance is authorized to alter or waive any of the conditions.

Received from _____ on (DATE)_____ the sum of $_____☐Check ☐By drafting first premium

Proposed Insured:_____ Life Insurance Amount:$_____ Plan of Insurance:_____

1. All of the following conditions must be met before insurance on the Proposed Insured may become effective prior to delivery of the certificate:
   a. The payment indicated above must have been received by SPJST or anticipation to draft first payment has been given and the financial institution has not notified SPJST that the draft will not be honored and be at least equal to an amount sufficient to keep the certificate in force for at least one month at the premium class applied. Provided, however; assuming all other conditions under this paragraph 1 have been met.
   b. All medical examinations and tests required by SPJST must be completed and received at the Home Office.
   c. As of the Effective Date, as defined below, the Proposed Insured must be a standard risk under rules and practices of SPJST for the plan and the amount of life insurance applied for, without change and at the rate of premium paid.
   d. As of the Effective Date, the state of health and all factors affecting the insurance of the Proposed Insured must be as stated in the application.
2. When each and every one of the conditions of Paragraph 1 have been met, then the lesser of, (a) the insurance coverage, as provided by the terms and conditions of the certificate of life insurance applied for, including accidental death coverage if applicable; or (b) insurance coverage shall not exceed the amount of $100,000 will begin as of the Effective Date. "Effective Date" as used herein, means the later of:
   a. The date of completion of the application; or
   b. The date of completion of all medical examinations, EKGs, blood/urine tests, and other tests required by SPJST.
3. There will be no conditional insurance coverage and SPJST liability will be limited to returning any premium submitted with this Conditional Receipt if any of the following occurs: (a) one or more of the Conditional Receipt's conditions have not be met exactly; (b) the Proposed Insured dies by suicide; or (c) SPJST does not approve and accept the application for insurance within sixty (60) days from the date of the Conditional Receipt.

   NO AGENT OR OTHER PERSON IS AUTHORIZED BY SPJST TO WAIVE OR MODIFY ANY OF THESE PROVISIONS OF THE CONDITIONAL RECIEPT.

   I understand and agree to the terms, conditions and limits of this receipt and the agreements in the application, all of which have been fully explained to me by the agent.

_____ _____

Proposed Insured or Purchaser if Proposed Insured is a minor Agent

LEAVE WITH APPLICANT