INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠
Royal Neighbors of America
230 16th Street
Rock Island, IL 61201
Toll-free (800) 627-4762
A Fraternal Benefit Society

Application for Individual Life Insurance

PART 1

SECTION 1– Proposed Insured

Name _____ Street _____

City _____ State _____ ZIP _____ Years at this address* _____

SSN/Tax ID _____ *If less than 3 yrs., add prior residence address in additional info, pg .4.

DOB _____ State/Country of birth _____ Marital status ❑ S ❑ M ❑ D Sex ❑ M ❑ F

Phone number ( ) _____

❑ U.S. driver's license ❑ Government issued ID ST _____ Annual income $ _____ Net worth $ _____

ID number _____ Employer's name _____

Email _____ Position/Title _____

Education ❑ High school ❑ 1+ college ❑ Bachelors ❑ Advanced Duties _____ Length of employment _____

Are you a U.S. citizen? ❑ Yes ❑ No If No, are you a legal U.S. resident (Green Card)? ❑ Yes ❑ No

Do you wish to designate another person (secondary addressee) to receive copies of any premium lapse notices? ❑ Yes ❑ No

Name _____ Address _____ Phone (_____) _____

SECTION 2 – Other Insurance

1. EXISTING or APPLIED FOR INSURANCE

Does the Proposed Insured have any existing or applied for life insurance *(L)* or annuity *(A)* contracts with this or any other company? ❑ Yes ❑ No **If Yes,** complete and submit state replacement forms, if required, with this application and provide details of all insurance, existing or applied for:

Company	Type *(L, A)*	Amount of Insurance	Year of Issue	Accidental Death Amount	Existing or Applied for
					❑ E ❑ A
					❑ E ❑ A

2. REPLACEMENT

In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction *(except conversions)* involving an annuity or other life insurance? ❑ Yes ❑ No **If Yes,** complete and submit a replacement questionnaire **AND** any other state required replacement forms with this application.

SECTION 3 – Proposed Owner/Petitioner**

****Complete if Proposed Owner is other than Proposed Insured or Proposed Insured is under age 15½**

Sex ❑ M ❑ F SSN/Tax ID _____ Relationship to Proposed Insured _____

Name _____ ❑ U.S. driver's license ❑ Government issued ID ST _____

Street _____ ID number _____

City _____ State _____ ZIP _____ Phone number ( ) _____ DOB _____

Are you a U.S. citizen? ❑ Yes ❑ No Email address _____

If No, are you a legal U.S. resident (Green Card)? ❑ Yes ❑ No

SECTION 4 – Beneficiary(ies) (If you have additional beneficiaries, please see page 4)

Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.

☒ PRIMARY

Name _____

Street _____

City _____ State _____ ZIP _____

DOB _____ SSN/Tax ID _____

Relationship to Proposed Insured _____

Percent of proceeds _____%

❑ PRIMARY ❑ CONTINGENT

Name _____

Street _____

City _____ State _____ ZIP _____

DOB _____ SSN/Tax ID _____

Relationship to Proposed Insured _____

Percent of proceeds _____%

SECTION 5 – Information Regarding Insurance Applied For

1. FACE AMOUNT $_____

2. RISK CLASS QUOTED _____

3. PRODUCT

A. WHOLE LIFE
- ❑ Level Pay *(to age 121)*
- ❑ Paid-up at Age 65
- ❑ 20-Pay Life

B. UNIVERSAL LIFE

❑ **Cash Accumulation**
Death Benefit Type: ❑ Option A or ❑ Option B
Planned Premium $_____

❑ **Death Benefit Guarantee**
Death Benefit Type: ❑ Option A only
Planned Premium $_____

4. AUTOMATIC PREMIUM LOAN (APL) will be provided.
- ❑ No Check if APL is NOT desired. *(Not applicable to Universal Life)*

5. DIVIDEND OPTION
- ❑ Applied to the payment of current premiums
- ❑ Paid in cash
- ❑ Applied to purchase paid-up additional insurance *(Not applicable to Universal Life)*
- ❑ Left on deposit to accumulate at interest

6. RIDERS (Check state availability)
- ☒ Accelerated Death Benefit - Terminal Illness *(**(to remove, striket hrough and Proposed Owner initial here** _____.)*
- ❑ Accelerated Death Benefit - Chronic Illness *(choosing this rider may affect eligibility for Government Programs.)*
- ❑ Accelerated Death Benefit - Critical Illness *(choosing this rider may affect eligibility for HDP.)*
- ❑ Accidental Death Face Amount: $_____
- ❑ Guaranteed Insurability Rider
- ❑ Premium Waiver Disability
- ❑ Waiver of Monthly Deduction
- ❑ Cancer Waiver
- ❑ Child Rider
- ❑ Flexible Premium Deferred Annuity Rider Planned Premium $_____ *(Mode is same as base Certificate.)*

SECTION 6 – General Risk Questions

Has the Proposed Insured:

1.	In the past 5 years, have you used chewing tobacco, cigarettes, cigars, or other tobacco products, or used any nicotine delivery products such as e-cigarettes, nicotine gum, lozenges or patch? **If Yes**, identify the date last used:	❑ Yes ❑ No
2.	In the past 5 years, done any flying other than as an airline passenger, or engaged in vehicle racing, underwater diving, or sky diving?	❑ Yes ❑ No
3.	Any current service with or entered into a written agreement to become a member of the armed forces?	❑ Yes ❑ No
4.	In the past 5 years, been convicted of one or more vehicle moving violations, driving under the influence of alcohol or drugs, or ever had a driver's license revoked or suspended?	❑ Yes ❑ No
5.	Ever had an application for life or health insurance declined, postponed, up-rated, or modified, or any insurance cancelled or its renewal refused?	❑ Yes ❑ No
6.	In the past 5 years, have you claimed disability benefits for an injury, illness, or impaired condition?	❑ Yes ❑ No
7.	Ever pleaded guilty to or been convicted of a felony or misdemeanor?	❑ Yes ❑ No
8.	Any plans within the next 2 years to travel or reside outside the U.S.?	❑ Yes ❑ No

Has the Proposed Insured or Proposed Owner:

9.	Entered into any agreement or arrangement providing for the future sale of the insurance Certificate applied for in this application?	❑ Yes ❑ No
10.	Entered into any agreement or arrangement where the Proposed Insured will receive financing or a loan, including forgivable loans, to pay some or all of the premiums, costs, or other expenses associated with this loan?	❑ Yes ❑ No
11.	Entered into any agreement either orally or in writing by which you are to receive any form of consideration in exchange for procuring the insurance Certificate you are applying for?	❑ Yes ❑ No

Details: If you answered YES to General Risk questions 2-11, please provide details below.

Question Number	Explanation

PART 2 (If exam is required, then PART 2 is optional. Please skip to PART 3.)

SECTION 1 – Proposed Insured Physician Information / Medical Information

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning the present health of the Proposed Insured.

Physician name _____ Name of practice/clinic_____

Street _____ City, State, ZIP _____

Phone number ( ) _____ Fax number ( ) _____

Date last consulted_____ Provide reasons for visit and the results._____

_____

List all currently prescribed medications, dosage, and frequency. _____

_____

1. Height_____ Weight_____ Experienced a change in weight *(greater than 10 pounds)* in the last 12 months? ❑ Yes ❑ No
If Yes, specify: Pounds lost_____ Pounds gained _____

2. Are your parents *(P)* or any siblings *(S)* deceased, or have they ever been treated by a member of the medical profession for heart disease, diabetes, cancer, or mental illness? (*If Yes, indicate below)* ..... ❑ Yes ❑ No

Relationship	Age at death	Diagnosis, cause of death
❑ P ❑ S		
❑ P ❑ S		

3. Have you ever received counseling or treatment from any physician for, or been advised by a physician to discontinue the use of alcohol or the use of prescribed, or non-prescribed drugs? ..... ❑ Yes ❑ No

4. In the past 10 years have you used amphetamines, barbiturates, cocaine, narcotics, marijuana, or other depressant, excitant, or hallucinatory drugs, unless administered on the advice of a physician?..... ❑ Yes ❑ No

5. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ..... ❑ Yes ❑ No

6. Have you ever been diagnosed as having, been treated by a member of the medical profession for, or tested positive for:

a. Heart attack; high blood pressure; stroke; TIA, cerebrovascular disease, or other disorder of the heart or blood vessels ? ..... ❑ Yes ❑ No

b. Cancer, tumor, cyst, mass; leukemia; lymph gland; thyroid; anemia or any other blood abnormalities?..... ❑ Yes ❑ No

c. Diabetes or other endocrine disorder; sugar, albumin, or blood in urine; pancreatitis; disorder of kidney, bladder, or prostate? .. ❑ Yes ❑ No

d. Asthma; bronchitis; emphysema; pneumonia; tuberculosis; or any other disorder of the lung/respiratory system? ..... ❑ Yes ❑ No

e. Intestinal bleeding; ulcer; hepatitis; or other disorder of throat, stomach, liver, intestine, or gallbladder?..... ❑ Yes ❑ No

f. Any disease or disorder of the reproductive system or breasts? ..... ❑ Yes ❑ No

g. Brain, mental, or emotional nervous disorder; dementia, Alzheimer's, eye disorder; epilepsy, seizures, paralysis; depression; anxiety; or any other disease or disorder of the nervous system?..... ❑ Yes ❑ No

h. Arthritis; loss of limb, or deformity; disorder of bone, joint, muscle, back, or spine; skin disorder, lupus, connective tissue disorder; or any other disorder of the musculoskeletal system? ..... ❑ Yes ❑ No

7. Excluding tests related to Human Immunodeficiency Virus (AIDS virus), during the past 5 years, have you:

a. Had any surgery or diagnostic test, such as an electrocardiogram, X-ray, MRI, CT scan, biopsy, or blood study? ❑ Yes ❑ No

b. Been advised to have any diagnostic test, hospitalization, or surgery that has not been completed?..... ❑ Yes ❑ No

c. Had treatment as an inpatient or outpatient or are you currently confined in a hospital, institution, clinic, or other medical facility? ..... ❑ Yes ❑ No

Details: If you answered YES to questions 3–7 in Section 1, please provide details here.

Question #	Name of Physician/Address	Illness Date/Duration	Diagnosis/Medications/Treatments

Additional Information

____

Additional Beneficiaries

Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.

❑ **PRIMARY** ❑ **CONTINGENT**
Name____________________
Street ____________________
City ______________ State ______ ZIP______
DOB __________ SSN/Tax ID______________
Relationship to Proposed Insured ______________
Percent of proceeds______________%

❑ **PRIMARY** ❑ **CONTINGENT**
Name ____________________
Street ____________________
City ______________ State ______ ZIP ______
DOB__________ SSN/Tax ID ______________
Relationship to Proposed Insured______________
Percent of proceeds______________%

❑ **PRIMARY** ❑ **CONTINGENT**
Name____________________
Street ____________________
City ______________ State ______ ZIP______
DOB __________ SSN/Tax ID______________
Relationship to Proposed Insured ______________
Percent of proceeds______________%

❑ **PRIMARY** ❑ **CONTINGENT**
Name ____________________
Street ____________________
City ______________ State ______ ZIP ______
DOB__________ SSN/Tax ID ______________
Relationship to Proposed Insured______________
Percent of proceeds______________%

PART 3

SECTION 1 – Payment Information

***If face amount is over $1 million or within the past 12 months the Proposed Insured has been treated by a member of the medical profession for heart trouble, stroke, or cancer, then payment (including drafting first payment) cannot be accepted with the application. Do not submit EFT form.**

1. PAYMENT MODE *(Check one)*

Direct bill: ❑ Annual ❑ Semi-Annual ❑ Quarterly

Electronic check/EFT: *(Complete form on page 7)*

❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly

❑ *Payment with app $_____ ❑ *Draft first payment

Additional details _____

2. BILLING ADDRESS INFORMATION

❑ Proposed Insured's address ❑ Proposed Owner/Petitioner's address

❑ Other Premium Payor's/Alternate billing address *(details below)*

Name _____

Street _____

City_____ State_____ ZIP _____

Agreement/Acknowledgement/Disclosure

We, the Proposed Insured, Proposed Owner, or Proposed Petitioner, if applicable, have read this application for life insurance including any amendments and supplements and, to the best of our knowledge and belief, all statements are true and complete. We also agree that:

- Statements in this application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any certificate issued.
- This application and any amendment(s) paramedical/medical exam, and supplement(s) to this application will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors of America (Royal Neighbors), become part of the new Certificate, and any copy or electronic image of these documents are as valid as the original and may be relied upon by Royal Neighbors in determining whether to issue the insurance for which I applied.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in this application and amendment(s), paramedical/medical exam, and any supplement(s).
- Only authorized officers of Royal Neighbors may: a) make or change any contract of insurance; b) make a binding promise about insurance; or c) change or waive any term of an application, receipt, or Certificate.
- Corrections, additions, or changes to this application may be made by Royal Neighbors. Any such changes will be shown under "Corrections and Amendments." Acceptance of a Certificate issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
- Unless otherwise provided by a Conditional Receipt, Royal Neighbors will have no liability under this application unless and until: a) it has been received and approved by Royal Neighbors at its Home Office; b) the Certificate has been issued and delivered to the Certificateowner; c) the first premium has been paid to and accepted by Royal Neighbors or authorization to draft first payment has been given and the financial institution has not notified Royal Neighbors 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.
- If not a current member, the Proposed Insured, applies to become a member of Royal Neighbors as indicated by the signature on page 6 and as a member, agrees to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors of America was founded more than 120 years ago.

Taxpayer Identification Number Certification

Under penalties of perjury, We, the Proposed Insured, or Parent, if a minor, or Proposed Owner certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2a. **Proposed Insured** – I am not subject to backup withholding because: a) I am exempt from backup withholding, or b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding, and

b. **Proposed Owner** – I am not subject to backup withholding because: a) I am exempt from backup withholding, or b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person.

Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. The IRS does not require your consent to any part of this form other than the certifications required to avoid backup withholding.

Authorization

I, the Proposed Insured, or Parent, if a minor, hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical facility, insurance or reinsurance company, MIB, Inc., consumer reporting agency, division of motor vehicles, the veterans administration, or other government agency or department having information as to the diagnosis, treatment, or prognosis with respect to any physical or mental condition, or having any non-medical information including any individually identifiable information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past 10 years, without restriction, to Royal Neighbors, its agents, employees, representatives, or its reinsurers. I further authorize Royal Neighbors, or its reinsurers, to make a brief report of my personal health information to MIB. This includes information on the treatment for alcohol, drug, and tobacco abuse, and psychiatric diagnosis and treatment. **In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, to give such information to any legal representative or agent employed by Royal Neighbors. I understand this authorization complies with the HIPAA Privacy Rule.**

I understand that the protected information is to be disclosed under this authorization so that Royal Neighbors may underwrite my application for life insurance, determine my eligibility for insurance, risk rating, or certificate issuance determinations, obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have applied for with Royal Neighbors. Any protected information obtained will not be released and/or reported by Royal Neighbors or its reinsurers to any person or organization EXCEPT to other divisions and/or departments of Royal Neighbors or its reinsuring companies, MIB, other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted, or other persons or organizations performing business or legal services in connection with my application, the insurance Certificate, or claim for benefits or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for 24 months or as permitted by applicable law in the state where the Certificate is delivered or issued for delivery from the date signed if used in connection with an application for life insurance certificate, an application for reinstatement of a life insurance certificate, or a request for change in Certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative is entitled to receive a copy. I understand that this authorization may be revoked by me at any time in writing, and if I refuse to sign or if I subsequently revoke this authorization, Royal Neighbors may not be able to process this application, and if coverage has been issued, may not be able to process any benefit payments. I agree that Royal Neighbors shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation at its Home Office or to the extent that Royal Neighbors has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be re-disclosed to such entities or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

Corrections and Amendments *(For Home Office Use Only)*

NOTICE: ROYAL NEIGHBORS OF AMERICA IS LICENSED TO DO BUSINESS IN THE STATE OF ILLINOIS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN THE ILLINOIS 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.

❑ I acknowledge receiving and signing the Rider Disclosure Statement, Form 9745-A, from my agent, if applicable.

SIGNATURES:

Signed at city, state _____ Date_____

Proposed Insured _____
(Sign if age 12 or older)

Signed at city, state _____ Date_____

Proposed Owner/Petitioner _____

Signed at city, state _____ Date_____

Signature of Parent _____
(Required for all applicants under age 18)

Agent's Report

Proposed Insured

1. Do you have any knowledge or reason to believe the Proposed Insured has any existing or applied for life insurance or annuity contracts with this or any other company? ..... ❑ Yes ❑ No
2. Do you have any knowledge or reason to believe the Proposed Insured has in-force life insurance or annuity contracts that may be replaced as a result of this transaction? ..... ❑ Yes ❑ No
3. If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? ..... ❑ Yes ❑ No
4. Did you personally review the I.D. of the Proposed Owner? ❑ Yes ❑ No If Yes, form of I.D. _____
5. Did you personally review the I.D. of the Proposed Insured? ❑ Yes ❑ No If Yes, form of I.D. _____
6. What is the premium to annual income ratio (annual premium divided into annual income)? _____
7. Was the Conditional Receipt left? ..... ❑ Yes ❑ No
8. Did you use written sales material approved for use by Royal Neighbors? ..... ❑ Yes ❑ No
9. Was Rider Disclosure Statement, Form 9745-A, delivered and signed by you and the Proposed Insured and Proposed Owner, if applicable? ..... ❑ Yes ❑ No

Note: Refer to language at top of Conditional Receipt for circumstances when Conditional Receipt should not be used.

Agent no._____ Agent license no. _____

Signature of Writing Agent _____ Date _____

Printed name of Writing Agent _____

If applicable, complete the following:

Agent Name_____ ID Number _____ Percent _____

Please print

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230 16th St.,Rock Island, IL 61201
(800) 627-4762
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Authorization for Electronic Funds Transfer (EFT)

I authorize Royal Neighbors of America and the bank named below to initiate automatic withdrawals from my checking/savings account. This authority will remain in effect until I give Royal Neighbors or the bank reasonable notice to stop payment on any withdrawal. (Royal Neighbors requires three days notice prior to scheduled withdrawals.)

❑ **Check to use bank information from attached voided check. Form must still be signed, dated, and payment selected.**

Name of financial institution _____

City _____ State _____

Name *(please print)*_____ Phone number ( ) _____

Address/PO Box _____

City _____ State_____ ZIP _____

I would like the payment withdrawn on the _____ day of the month (Quarterly, semi-annual, or annual payments also available.) **OR** the _____2nd _____3rd _____4th Wednesday of the month. (If nothing is selected withdrawals will default to the 5th day of the month.)

Routing # _____ Checking acct # _____ OR Savings acct # _____

(DEBIT AND CREDIT CARD NUMBERS ARE NOT ACCEPTABLE)

Signature as it appears on bank records **X** _____ Date _____

PLEASE RETURN THIS AUTHORIZATION WITH A VOIDED CHECK.

IMPORTANT: If face amount is over $1 million or if within the past 12 months the Proposed Insured has been treated by a member of the medical profession for heart trouble, stroke, or cancer, payment (including authorization to draft the first premium) cannot be received with application and no conditional receipt may be given and there will be no coverage under any conditional receipt.

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230 16th Street
Rock Island, IL 61201
Toll-free (800) 627-4762
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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 Royal Neighbors of America (Royal Neighbors) is authorized to alter or waive any of the conditions.

Received from _____ (Date)_____ the sum of $_____ ❑ Check ❑ By drafting first premium

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

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 Royal Neighbors or anticipation to draft first payment has been given and the financial institution has not notified Royal Neighbors 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 for. Provided, however; assuming all other conditions under this paragraph 1 have been met, if Royal Neighbors, in accordance with its rules, would have issued the Certificate under a different premium class than applied for, and the premium paid was less than the premium that would have been required for the issuance of a certificate at this new premium class, then the death benefit payable under the receipt shall be such as the premium paid would have purchased at this new premium class.
   b) All medical examinations and tests required by Royal Neighbors must be completed and received at the Home Office of Royal Neighbors.
   c) As of the Effective Date, as defined below, the Proposed Insured must be a standard risk under rules and practices of Royal Neighbors 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 in the amount of $1,000,000; 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, electrocardiograms, blood/urine tests, and other tests required by Royal Neighbors.
3. There will be no conditional insurance coverage and Royal Neighbors' liability will be limited to returning any premium submitted to Royal Neighbors with this Conditional Receipt if any of the following occurs: (a) one or more of the Conditional Receipt's conditions have not been met exactly; (b) the Proposed Insured dies by suicide; or (c) Royal Neighbors 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 ROYAL NEIGHBORS TO WAIVE OR MODIFY ANY OF THE PROVISIONS OF THE CONDITIONAL RECEIPT.

Signature of Agent Receiving the Payment_____

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.

Signature of Proposed Owner/Petitioner _____

***** MUST BE LEFT WITH PROPOSED INSURED/OWNER *****

MIB, Inc., Notice

This Notice is to be detached, read, and retained by the Proposed Insured

Information regarding your insurability will be treated as confidential. Royal Neighbors or its reinsurers make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of 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 if 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. 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 Report Act. The address of MIB's information office is: MIB, 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

Royal Neighbors or its reinsurers may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

Fair Credit Report Act Notice

This is to inform you that as part of our underwriting procedures in connection with this application, an investigative consumer report may be obtained on the Proposed Insured and the Proposed Petitioner. This report will provide applicable information concerning character, general reputation, personal characteristics, and mode of living.* This information will be obtained through personal interviews with neighbors, friends, and associates. You may request to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. No information collected concerning the sexual orientation of the Proposed Insured or Proposed Petitioner will be used to determine her or his eligibility for life insurance.

**Information obtained will not be used to determine sexual orientation.*

***** MUST BE LEFT WITH PROPOSED INSURED *****

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