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, strike through 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)*

FRAUD NOTICE/WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

❑ 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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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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Royal Neighbors of America

www.royalneighbors.org

Rock Island Home Office • 230 16th St., Rock Island, IL 61201 • (800) 627-4762

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230 16th Street • Rock Island, IL 61201
(309) 788-4561 • (800) 627-4762
contact@royalneighbors.org • www.royalneighbors.org

Disclosure Notice For Life Insurance Illustration

Name of Applicant/Proposed Insured (Print) _____ (Date of Royal Neighbors Application) _____

Address _____

Royal Neighbors Field Representative's Name (Print) _____ (Territory) _____

Complete Section A, B or C as Applicable

Section A

I acknowledge/certify that no presentation, depiction, or illustration discussing or showing projected values which are not guaranteed was used during the sales interview.

(Applicant's/Petitioner's Signature) _____ (Field Representative's Signature) _____

Section B

I acknowledge/certify that the illustration shown during the sales interview does not specifically conform with the insurance plan as applied for.

(Applicant's/Petitioner's Signature) _____ (Field Representative's Signature) _____

Section C

I certify that I displayed a computer screen illustration for _____
(Name of Applicant/Petitioner)

that complies with state requirements and for which no hard copy was furnished. The illustration used was based on the following personal and certificate (policy) information:

1. Gender _____ Male _____ Female
2. Underwriting/Rating Class_____
3. Age _____
4. Type of Certificate Displayed_____
5. Initial Death Benefit $ _____
6. Dividend Option (if applicable) _____
7. Type of Rider Displayed (if any) _____
8. Guaranteed Interest rate Illustrated (if applicable) _____
9. Non-Guaranteed Interest Rate Illustrated (if applicable) _____

(Date) _____ (Signature of Royal Neighbors Field Representative) _____

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No hard copy of the illustration was furnished to me.

(Date) _____ (Signature of Applicant/Petitioner)) _____

Section D MUST BE COMPLETED:

I understand that an illustration conforming to the Certificate (policy) as issued will be provided to me no later than at the time the certificate is delivered to me.

(Signature of Applicant/Petitioner) _____ (Date) _____

White: Home Office Yellow: Applicant/Petitioner Pink: FR Records

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230 16th Street • Rock Island, IL 61201
(309) 788-4561 • (800) 627-4762
contact@royalneighbors.org • www.royalneighbors.org

IMPORTANT NOTICE REGARDING REPLACEMENT

DEFINITION: REPLACEMENT IS any transaction where, in connection with the purchase of New Insurance or a New Annuity, you LAPSE, SURRENDER, CONVERT to Paid-up Insurance, Place on Extended Term, or BORROW all or part of the certificate loan values on an existing insurance certificate or an annuity (See reverse side for DEFINITIONS).

IF YOU INTEND TO REPLACE COVERAGE: In connection with the purchase of this insurance or annuity, if you have REPLACED or intend to REPLACE your present life insurance coverage or annuity(ies), you should be certain that you understand all the relevant factors involved. You should BE AWARE that you may be required to provide (EVIDENCE OF INSURABILITY) and

1) If your HEALTH condition has CHANGED since the application was taken on your present certificates, you may be required to pay ADDITIONAL PREMIUMS under the NEW CERTIFICATE, or be DENIED coverage.
2) Your present occupation or activities (may not be covered or could require additional premiums.)
3) The INCONTESTABLE and SUICIDE CLAUSE will begin anew in a new certificate. This could RESULT in a (CLAIM under the new certificate BEING DENIED) that would otherwise have been paid.
4) Current law DOES NOT REQUIRE your present insurer(s) to REFUND any premiums.
5) It is to your advantage to OBTAIN INFORMATION regarding your existing certificates or annuity contracts (from the insurer or agent from whom you purchased the certificate or annuity contract.)

   (If you are purchasing an annuity, clauses (1), (2), and (3) above would not apply to the new annuity contract.)

THE INSURANCE OR ANNUITY I INTEND TO PURCHASE FROM ROYAL NEIGHBORS OF AMERICA MAY REPLACE OR ALTER EXISTING LIFE INSURANCE CERTIFICATE(S) OR ANNUITY CONTRACT(S).

The following certificate(s) or annuity contract(s) may be replaced as a result of this transaction:

(Insurer as it appears on the certificate or contract)	(Insured as it appears on the certificate or contract)
_____	_____
_____	_____
_____	_____
_____	_____
(Certificate or Contract Number)	**(Insured Birthdate)**
_____	_____
_____	_____
_____	_____
_____	_____

The proposed certificate or contract is:

_____ $_____
Type of certificate generic name — Face Amount

_____ _____
Signature of applicant — Date

_____
Address of applicant — City — State

I certify that this form was given to and completed by

_____
(Applicant-please print or type)

prior to taking an application and that I am leaving a signed copy for the applicant

_____ _____
Agent's signature — Date

_____
Address — City — State

White copy - Home Office *Yellow copy - Applicant*

DEFINITIONS

PREMIUMS: Premiums are the payments you make in exchange for an insurance certificate 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.

INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠

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Replacement Questionnaire

Existing Life Insurance or Annuity

Name of existing insurer: _____

Date issued: _____

Type of plan: _____

Face amount (if life insurance): $_____

Premium amt: $_____ mode: A/S/Q/PAC/OTHER

Identify if premiums are increasing/decreasing/level/paid-up

Riders (type and premium paid) _____

Is the contract receiving dividends (participating)? yes/no

Has the contestable period expired? yes / no

Has the suicide period expired? yes / no

If universal life or annuity, list
the guaranteed interest rate of the contract _____%

If universal life, will the planned premium carry the contract to maturity at the guaranteed interest rate? yes / no

State the total amount(s) of applicable surrender/withdrawal charges that the contract will be charged if replaced: $_____

Proposed Royal Neighbors of America Life Insurance or Annuity

Name of proposed insurer: Royal Neighbors of America

Date issued: not applicable

Type of plan: _____

Proposed face amount (if life insurance): $_____

Proposed premium amt: $_____ mode: A/S/Q/PAC

Identify if premiums will be increasing/decreasing/level/paid-up

Proposed riders (type and premium) _____

Will the proposed contract be participating in dividends? yes / no

Will the proposed contract have a contestable period? yes / no

Will the proposed contract have a suicide period? yes / no

If proposed contract is a universal life or annuity list
the guaranteed interest rate _____%

If proposed contract is a universal life, will the planned premium carry the contract to maturity at the non-guaranteed midpoint rate? yes / no

Will the proposed contract have new surrender or withdrawal charges on it? yes / no

The reason(s) the existing life insurance or annuity is not suitable for the insured/annuitant's present needs is because:_____

_____

_____

If the proposed insurance is universal life, or term life that is or may be annual renewable, has the proposed insured been advised that the cost of insurance or premiums will increase with each attained age? yes / no / na

If the present life insurance is universal adjustable life, has the insured been advised that she/he should contact their present insurer to inquire whether the present coverage can be changed contractually to meet the insured's current needs? yes / no / na

Will the proposed replacement involve an Internal Revenue Section 1035 Exchange or Direct Rollover? yes / no / na

Has the proposed applicant/petitioner been advised that if a policy loan is extinguished by a cash surrender or in connection with a Section 1035 Exchange, any gain will be recognized to the extent of the cash or other non-like kind property received and may be subject to income tax liability at the time of the transaction? yes / no / na

I have read and understand the information stated above regarding some of the advantages and disadvantages of replacing my existing life insurance coverage or annuity contract with a new life insurance or annuity certificate issued by Royal Neighbors of America. I also understand that the new certificate may have suicide and contestable provisions, which may affect the payment of a claim made under the new certificate.

_____
Signature of the applicant or petitioner

_____
Signature of Agent

_____
Date

_____
Date

_____
Date of application for Royal Neighbors of America life insurance or annuity

_____
Agent ID#

white copy-Home Office yellow copy-agent. file pink copy-applicant or petitioner