B'nai B'rith
Insurance Program

# *Group Term Life Insurance Application*

Underwritten by **Monumental Life Insurance Company, Cedar Rapids, IA**

Please complete the entire application. Print clearly in dark ink and mail to:
Group Term Life Administrator, 6110 Parkland Boulevard, Cleveland, OH 44124-4187.
Phone: 1-800-723-BNAI (2624)

## 1 MEMBER INFORMATION

**Policy No. MZ0909533H0000A**

Member's Name _____ ❑ Male ❑ Female Date of Birth _____/_____ /_____
LAST FIRST MI

Height *(feet/inches)* _____ Weight *(pounds)* _____

Address _____ City _____ State _____ Zip _____

**PREFERRED EMAIL**_____ Home Phone (  )_____ Work Phone (  ) _____

### SPOUSE COVERAGE *(only if applying)*

Spouse's Name _____ ❑ Male ❑ Female Date of Birth _____/_____ /_____
LAST FIRST MI

Height *(feet/inches)* _____ Weight *(pounds)* _____

### DEPENDENT COVERAGE (*Attach additional sheet if necessary.)*

**Applying for $10,000 of coverage per child listed below:**

Child's Name _____ Date of Birth ____/____ /____ ❑ Male ❑ Female
LAST FIRST MI

Child's Name _____ Date of Birth ____/____ /____ ❑ Male ❑ Female
LAST FIRST MI

Child's Name _____ Date of Birth ____/____ /____ ❑ Male ❑ Female
LAST FIRST MI

Child's Name _____ Date of Birth ____/____ /____ ❑ Male ❑ Female
LAST FIRST MI

## 2 Please complete the following:

| | Member | Spouse (ONLY IF APPLYING) |
|---|---|---|
| 1. Have you used tobacco products of any kind in the last 12 months? | ❑ Yes ❑ No | ❑Yes ❑ No |
| 2. Is this insurance intended, in whole or in part to replace, discontinue, or change any existing life insurance or annuity now in effect with this or any other company? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| **If yes,** please give name of Company:_____ and Policy Number:_____ | | |

| | | | | |
|---|---|---|---|---|
| 3. If you are a new applicant, indicate desired amount of coverage: | **Member:** | ❑ $50,000 | ❑ $100,000 | ❑ $150,000 |
| | **Spouse:** | ❑ $50,000 | ❑ $100,000 | ❑ $150,000 |
| 4. If you are increasing coverage indicate amount of additional coverage: | **Member:** | ❑ $50,000 | ❑ $100,000 | *(Total not to exceed $150,000)* |
| | **Spouse:** | ❑ $50,000 | ❑ $100,000 | *(Total not to exceed $150,000)* |

## 3 Statement of Health

Each applicant, please answer all questions:

| | Member | Spouse (ONLY IF APPLYING) |
|---|---|---|
| 1. Have you ever had chest pains, disease or disorder of the heart, liver, kidneys or lungs, high blood pressure, albumin or sugar in your urine, diabetes, cancer, tumors or ulcers? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| 2. Have you ever had or been treated for heart trouble, stroke, Hepatitis B or C, high blood pressure, ulcerative colitis, kidney or liver disorder, blood or circulatory disorder, diabetes, any mental or nervous disorder, drug abuse or alcoholism, lung disorder, cancer or tumors? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| 3. Have you, during the past 24 months, consulted a physician or other Practitioner, received treatment for any disease, ailment or injury or been confined or treated in any hospital or similar Institution? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| 4. Have you ever had, been told you had or have you ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related condition? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| 5. Have you had any condition for which hospitalization or surgery has been advised, or is contemplated, within the next year? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| 6. Are you involved in the operation of an aircraft, car racing, water racing or involved in sports such as bungee jumping, scuba diving, amateur or interscholastic athletics, hang gliding, ballooning, parasailing, mountain climbing, or hunting? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| 7. Have you ever applied for life or health insurance, which has been declined, rated, or modified in any way? | ❑ Yes ❑ No | ❑ Yes ❑ No |

**Please give full details if you or your spouse answered "YES" to any of the above questions.**
*(Use separate sheet if necessary.)*

▸▸**PLEASE NOTE:** INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF YOUR APPLICATION. ◂◂

| Name of Proposed Insured | Nature of Illness, Injury or Operation | Dates of Treatment | Remaining Effects | Physician Name, Address & Telephone |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| | Member | Spouse (ONLY IF APPLYING) |
|---|---|---|
| 8. Do you take prescription medications or over the counter medications?<br>**If yes**, please list: _____ | ❑ Yes ❑ No | ❑ Yes ❑ No |

## 4

**BENEFICIARY INFORMATION** *List one or more beneficiaries below. Beneficiaries may include your spouse, children, parents, charities or anyone you wish. (Use a separate sheet if necessary*.)*

| **Member's Beneficiary:** | | | |
|---|---|---|---|
| Name | Address | Relationship | Percentage |
| Name | Address | Relationship | Percentage |
| **Spouse's Beneficiary:** | | | |
| Name | Address | Relationship | Percentage |
| Name | Address | Relationship | Percentage |

**The beneficiaries will share equally unless you make a written request to the contrary.*

**5** **CONVENIENT PAYMENT PLAN** Please read the enclosed **Account Deduction Authorization Agreements & Conditions** form. I hereby authorize the necessary **Financial Institution** deductions for the Term Life coverage from one of the following accounts:

| ❑ **Checking** Enclose voided check. | ❑ **Savings** Enclose Deposit Slip. | Financial Institution Name: | |
|---|---|---|---|
| Account Number: | | Deduction should be taken: ❑Quarterly ❑Semi-Annually ❑Annually | |
| Name(s) on Account: | | Signature: | Date: |

**-OR-**

| ❑ **Enclosed is my first** | ❑ Semi-Annual<br>❑ Annual | **premium payment made payable to SELMAN & COMPANY.** |
|---|---|---|

**6** I hereby apply for the Group Term Life Insurance Plan underwritten by Monumental Life Insurance Company. I understand and affirm by my signature below that all statements are, to the best of my knowledge and belief, true, full, complete and correctly recorded. I understand that all insurance coverage under this policy is null and void if I have made a false statement, material misrepresentation or omission, or failed to update the Company on any health status change prior to the effective date of this coverage. To determine my insurability or for claims purposes, I authorize any medical practitioner, institution, VA Hospital, insurance company or person having knowledge of my health, or the MIB to give any information about my physical or mental health to Monumental Life Insurance Company, Admin. Office: Baltimore, MD 21202-1098, or its authorized representatives. This authorization, original or copy, is valid for two years from the effective date of coverage. I acknowledge receiving the "NOTIFICATION" regarding the MIB.

I understand that the coverage will take effect on the Effective Date shown on the Certificate of Insurance, provided the first premium has been paid and there has been no change in my insurability since the date of the application. I understand that I am obligated to notify Monumental Life Insurance Company in writing if my health status changes to the extent it would change or otherwise alter one or more of my answers to these application questions.

►► **Member's Signature**: _____ Date Signed: ____/____/_____

►► **Spouse's Signature**: *(only if applying)* _____ Date Signed: ____/____/_____

**NOTICE TO APPLICANT(S) - PLEASE READ**

Insurance regulations require that we send you this statement using the following wording:

"Information regarding your insurability will be treated as confidential. Monumental Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file."

"Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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, Massachusetts 02184-8734."

"Monumental Life Insurance Company, 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."

Public Law 91-508 requires that we advise you that a routine inquiry may be made which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

**SUMMARY NOTICE OF INFORMATION PRACTICES**

As part of the underwriting and processing of your application for insurance coverage, this Company will rely heavily on information provided by you. The Insurance Company also seeks information about you, from others, such as physicians who have treated you or family members.

In some situations, and in compliance with applicable laws, we may disclose certain of the information to third parties without your specific authorization.

You have a right of access and correction with respect to all personal information collected about you which is contained in our files. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of Monumental Life Insurance Company's information practices. If you would like to receive a more detailed explanation of those practices, please contact our Underwriting Department, Monumental Life Insurance Company, Administrative Office: 100 Light Street, Floor B1, Baltimore, MD 21202-1098.

**Please retain this document for your records.**

## *Account Deduction Authorization Agreements & Conditions*

Automatic Payment Option (Account Deduction Authorization) is subject to the following Conditions:

1. Premium payments will be debited from your account on or about the premium due date.
2. Additional premium that may be required in order to keep policy(ies)/certificate(s) current may be drawn from your account through the use of multiple debits.
3. Selman & Company (Company) may revoke the privilege of paying premium under this Automatic Payment Option (APO) if any payment is dishonored.
4. A service fee of $15.00 may be assessed for each dishonored payment.
5. Payment of premium under APO may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
6. If APO is discontinued, an alternate payment mode acceptable to the Company will be used to remit the premiums needed to keep the policy(ies)/certificate(s) in force and current.
7. The Company will not send premium notices while APO is in effect.
8. A request for change or adjustment to the APO must be sent directly to the Company's Customer Service Department.
9. If you cancel this service, any refund of premium due you will take sixty (60) days to process.

*In accordance with the agreements and conditions stated above, by completing and signing the Enrollment Form, I hereby request and authorize Selman & Company to initiate debit entries on the Financial Institution account listed in the insurance Enrollment Form for the purpose of paying premium. This authorization is to remain in full force and effect until Company and Depository have received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on such notification. Written notification must be mailed to:*

***Selman & Company***
***6110 Parkland Boulevard***
***Cleveland, OH 44124-4187***

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**Please retain this document for your records.**