

# Individual Graded Death Benefit Life Insurance Application



**SONS of  
NORWAY**

1455 West Lake Street  
Minneapolis, MN 55408-2666  
Toll-free: 800-945-8851  
Phone: 612-827-3611  
[www.sonsofnorway.com](http://www.sonsofnorway.com)

## 1 Proposed Insured - Current Sons of Norway Member? Yes No

\_\_\_\_\_  
First name                                      Middle Initial      Last name                                      Sex                                      Date of Birth (mm/dd/yy)

\_\_\_\_\_  
Home address (Street Address, City, State, Zip)

\_\_\_\_\_  
Phone No.                                      Email Address                                      Social Security Number

- ## 2
- Applicant/Owner** - if other than the Proposed Insured  
Current Sons of Norway member?  Yes  No
  - Payor** - if other than Owner

\_\_\_\_\_  
Name                                      Relationship to Proposed Insured                                      Social Security No.

\_\_\_\_\_  
Home address (Street Address, City, State, Zip)

\_\_\_\_\_  
Home Phone No.                                      Work Phone No

*All notices and reports will be sent to the Owner unless otherwise specified*

## 3 Insurance Applied For

\$      Amount                                      \$      Premium                                      Premium Mode       Monthly       Quarterly       Semi-Annual       Annual

Does the person proposed for insurance have life insurance or annuities in force? (If yes, give details below.) .....  Yes  No

Is the certificate applied for to replace or change any existing insurance or annuities with this or any other company?  
(If yes, give details below.).....  Yes  No

Company	Policy Number	Replace or Change	Coverage Amount

## 4 Beneficiary - (If multiple beneficiaries are named, shares will be divided equally or to the survivor(s) unless otherwise specified.)

Primary:      Name                                      Birth Date                                      SS#                                      Relationship

Contingent:      Name                                      Birth Date                                      SS#                                      Relationship

## 5 Authorization for Automatic Withdrawal (AWP)

### Section 1 - Transaction Requested

#### Establish New AWP Account

I authorize Sons of Norway to make an immediate electronic draw from the bank account listed below upon receipt of this form.

- One time payment
- Ongoing payment deducted monthly on the  first or  fifteenth

#### Add to Existing AWP

Name of bank account owner: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Full name of bank: \_\_\_\_\_ Routing number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_  Checking or  Savings

### Section 2 - Agreements and Signature

#### General Authorization

I authorize Sons of Norway to:

- Make electronic deposits, withdrawals, and corrections to my bank account that comply with U.S. law.
- Act on this authorization until I revoke it by contacting Sons of Norway.
- Make administrative changes to this authorization such as date and amount changes, or adding or removing certificates for automatic payment.
- Act upon electronic deposit, withdrawal, and administrative instructions I provide.

\_\_\_\_\_  
Signature of bank account owner

\_\_\_\_\_  
Date

## 6 Declarations By Proposed Insured

I represent that all statements and answers made in all parts of this application are full, complete and true to the best of my knowledge and belief. It is agreed that:

1. All such statements and answers shall be the basis for and a part of any certificate issued.
2. No representative can accept risks, make or change contracts, or waive Sons of Norway's rights, or requirements.
3. No insurance shall take effect unless the proposed insured is alive when the certificate is delivered and the full premium is received in Sons of Norway Headquarters.
4. I understand that a reduced death benefit amount is payable during the first two years if death results from sickness or other natural causes.

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.

**X** \_\_\_\_\_  
Signature of proposed insured Date signed

**X** \_\_\_\_\_  
Signature of applicant/owner (if other than proposed insured) Date signed

I certify that I asked each question on the application as printed, recorded the answers exactly as given, and witnessed the signing of the application. Also, I certify that the insurance application is not intended to replace or change any insurance except as indicated above.

**X** \_\_\_\_\_  
Witnessed by Financial Benefits Counselor FBC number Date signed

\_\_\_\_\_  
City and state where signed FBC license #