# Individual Graded Death Benefit
# Life Insurance Application
ILLINOIS

SONS of NORWAY
1455 West Lake Street
Minneapolis, MN 55408-2666
Toll-free: 800-945-8851
Phone: 612-827-3611
www.sonsofnorway.com

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

Norwegian by ☐ Birth ☐ Descent ☐ Marriage/Spouse ☐ Interest/Affiliation

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

Norwegian by ☐ Birth ☐ Descent ☐ Marriage/Spouse ☐ Interest/Affiliation

☐ **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 | Dues | 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.

**SONS OF NORWAY 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.**

X_____ _____

Signature of proposed insured Date signed

X_____ _____

Signature of applicant/owner (if other than proposed insured) Date signed

X_____ _____ _____

Signature of witness City and State where signed Date signed

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

X_____ _____ _____ _____

Signature of Agent Agent number Agent license number Date signed