Life Insurance Application

SONS OF NORWAY
1455 West Lake Street
Minneapolis, MN 55408
Toll Free (800) 945-8851

1 Proposed Insured 1 – Current Sons of Norway Member? ☐ yes ☐ no

Name | Birth Date | State of Birth | Marital Status | Sex

Social Security No. | Driver's License No. & State | Home Phone No. | Work Phone No.

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

Employer's Name | Employer's Address

Occupation _____ Annual Income $_____ Net Worth $_____

2 Proposed Insured 2 – Current Sons of Norway Member? ☐ yes ☐ no Relationship to Insured1: _____

Name | Birth Date | State of Birth | Marital Status | Sex

Social Security No. | Driver's License No. & State | Home Phone No. | Work Phone No.

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

Employer's Name | Employer's Address

Occupation _____ Annual Income $_____ Net Worth $_____

3 ☐ Applicant/Owner if other than a Proposed Insured (Owner must sign Page 5)

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 in No. 19

4 Base Plan of Insurance ☐ UL ☐ Term ( ) Yrs ☐ V-23 ☐ Other _____

Amount Applied For	If UL - Option	Amount of Premium w/ App.	Dues w/ App.	Premium Mode	Modal Premium
$	☐ 1 ☐ 2	$	$	☐ Annual ☐ Semi-Annual ☐ Single ☐ Quarterly ☐ AWP	$

Underwriting Class: ☐ Super Select Non-Tobacco ☐ Select Non-Tobacco ☐ Std Non-Tobacco ☐ Tobacco ☐ juvenile (age 0 – 17)

Dividend Option: ☐ Cash ☐ Reduce Premium ☐ Paid–up Addition ☐ Accumulate at Interest

5 Riders/Benefits

☐ Primary Insured Term Rider $ ( )yrs

☐ Other Insured Term Rider $ ( ) yrs
Underwriting Class _____

☐ Waiver | ☐ Guaranteed Purchase Option $ | ☐ Accidental Death Benefit $ _____ | ☐ Automatic Premium Loan

☐ Terminal Illness Rider | ☐ Convalescent Care Rider | ☐ Other _____

6 Children to be Covered Under CIR

OF UNITS _____

NAME(S)	AGE	BIRTHDATE	SOCIAL SECURITY NUMBER	HEIGHT	WEIGHT	BIRTHPLACE	NAME OF BENEFICIARY
			COMPLETE ONLY IF APPLYING FOR CHILDREN'S RIDER				

7 Life Insurance in Force: IF NONE, SO STATE.

Use number 12 if additional space is needed.

PERSON	COMPANY	POLICY NUMBER	REPLACE OR CHANGE?	PERSONAL COVERAGE AMOUNT	BUSINESS COVERAGE AMOUNT	YEAR ISSUED

Regarding all Persons Proposed for Insurance:

EACH PERSON TO BE INSURED

		PROP. INS. 1 YES	PROP. INS. 1 NO	PROP. INS. 2 YES	PROP. INS. 2 NO	DEPENDENTS YES	DEPENDENTS NO
(a)	Is the certificate applied for to replace or change any existing insurance or annuities with this or any other company? *(If "Yes", indicate in the above chart which policy and complete all state required forms)*	☐	☐	☐	☐	☐	☐
(b)	Does any person proposed for insurance have an application pending with another company? *(If "Yes", give Person, Company and Amount in #12 below.)*	☐	☐	☐	☐	☐	☐
(c)	Has any person proposed for insurance ever been rated up, declined or postponed for life or health insurance coverage? *(If "Yes", give details in #12 below.)*	☐	☐	☐	☐	☐	☐

8 Tobacco Use Is anyone proposed for insurance currently using, or used in the past, any form of tobacco or nicotine substitute ?

	WITHIN 12 MONTHS		WITHIN 24 MONTHS		WITHIN 36 MONTHS	
PROPOSED INSURED 1	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO
PROPOSED INSURED 2	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO

9 Within the last 24 months has any Person Proposed for Insurance: (If "Yes", complete applicable questionnaire)

		PROP. INS. 1 YES	PROP. INS. 1 NO	PROP. INS. 2 YES	PROP. INS. 2 NO	DEPENDENTS YES	DEPENDENTS NO
(a)	Flown as a pilot, student pilot or crew member?	☐	☐	☐	☐	☐	☐
(b)	Are any such flights planned in the future?	☐	☐	☐	☐	☐	☐
(c)	Engaged in ☐ hang gliding ☐ mountain climbing ☐ sky diving ☐ racing ☐ scuba diving?	☐	☐	☐	☐	☐	☐

10 Has any Person Proposed for Insurance: (If "Yes", give full details in Number 12)

		PROP. INS. 1 YES	PROP. INS. 1 NO	PROP. INS. 2 YES	PROP. INS. 2 NO	DEPENDENTS YES	DEPENDENTS NO
(a)	Had any motor vehicle accident, DUIs, DWIs, speeding tickets, or other traffic violations in the past 5 years?	☐	☐	☐	☐	☐	☐
(b)	Been convicted of a felony in the past 10 years?	☐	☐	☐	☐	☐	☐

11 Is any Person Proposed for Insurance: (If "Yes", give full details in Number 12)

		PROP. INS. 1 YES	PROP. INS. 1 NO	PROP. INS. 2 YES	PROP. INS. 2 NO	DEPENDENTS YES	DEPENDENTS NO
(a)	☐ A non U.S. citizen or ☐ resides more than 6 months a year outside of the United States or Canada?	☐	☐	☐	☐	☐	☐
(b)	Not a permanent resident of the United States, Puerto Rico or Canada?	☐	☐	☐	☐	☐	☐
(c)	Intending to travel outside of the United States or Canada within the next 12 months?	☐	☐	☐	☐	☐	☐

12 Details to questions 7-11.

PERSON	QUESTION	DATE OF EVENT	DETAILS

NON-MEDICAL DECLARATIONS

13 (a) Proposed Insured 1: Height _____ Weight _____ ☐ Gain ☐ Loss in past year? _____lbs.
(b) Proposed Insured 2: Height _____ Weight _____ ☐ Gain ☐ Loss in past year? _____lbs.

14 **Within the past 10 years** has any person proposed for insurance been treated or diagnosed by a physician as having: (Circle conditions to which "Yes" answer applies and give details in number 16 below.)

	EACH PERSON TO BE INSURED					
	Prop. Ins. 1		Prop. Ins. 2		Dependents	
	Yes	No	Yes	No	Yes	No
(a) Disorder of brain or spinal cord, paralysis, epilepsy, stroke, convulsions, chronic headaches?	☐	☐	☐	☐	☐	☐
(b) Asthma, bronchitis, emphysema, tuberculosis or other disorder of the lungs or respiratory system?	☐	☐	☐	☐	☐	☐
(c) High blood pressure, heart attack, heart murmur, chest pain or other disorder of the heart or blood vessels?	☐	☐	☐	☐	☐	☐
(d) Hepatitis C, any disorder of the liver, pancreas, esophagus, stomach or intestines?	☐	☐	☐	☐	☐	☐
(e) Sugar or blood in the urine, chronic inflammation or other disorder of the kidneys?	☐	☐	☐	☐	☐	☐
(f) Cancer, tumor or disorder of the prostate or reproductive organs?	☐	☐	☐	☐	☐	☐
(g) Arthritis, osteoporosis or other disorder of the muscles, skin or bones including joints or spine?	☐	☐	☐	☐	☐	☐
(h) Diabetes, recurrent infections, enlarged lymph glands, anemia, excess fatigue or other disorders of the glandular or blood systems?	☐	☐	☐	☐	☐	☐
(j) Psychiatric or mental health disease or disorder, including depression?	☐	☐	☐	☐	☐	☐
(j) Immune system disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or test results indicating exposure to the AIDS virus?	☐	☐	☐	☐	☐	☐

15 **Has any Person Proposed for Insurance:** (Circle conditions to which "Yes" answer applies and give details in number 16 below.)

	Prop. Ins. 1		Prop. Ins. 2		Dependents	
	Yes	No	Yes	No	Yes	No
(a) Other than above, had examination, treatment or consultation with a physician during the past 5 years?	☐	☐	☐	☐	☐	☐
(b) Now taking medication, prescription drugs, or receiving counseling or treatment?	☐	☐	☐	☐	☐	☐
(c) Within the past 5 years been advised to have counseling or treatment regarding abuse of alcohol or any drug?	☐	☐	☐	☐	☐	☐
(d) Within the past 5 years used marijuana, heroin, methamphetamine, cocaine, or been convicted for the possession of drugs?	☐	☐	☐	☐	☐	☐
(e) Had parent, brother or sister who died before the age of 65 due to heart disease, cancer, diabetes or cerebrovascular disease?	☐	☐	☐	☐	☐	☐

16 **Details to questions 14-15.**

Person	Question	Date of Diagnosis	Diagnosis - Medication Prescribed	Full Name, Complete Address and Phone Number of Attending Physician or Hospital

17 Insured #1 Beneficiary (If multiple beneficiaries named, shares will be divided equally or to the survivor(s) unless otherwise specified.)

	Name	Birth Date	SS#	Relationship
Primary:				
Contingent:	Name	Birth Date	SS#	Relationship

Insured #2 Beneficiary (If multiple beneficiaries named, shares will be divided equally or to the survivor(s) unless otherwise specified.)

	Name	Birth Date	SS#	Relationship
Primary:				
Contingent:	Name	Birth Date	SS#	Relationship

18 AUTHORIZATION FOR AUTOMATIC WITHDRAWAL

Name of Depositor as it appears on Banking Institution Records

Account or Code Number

Name of Banking Institution

Branch

Address of Banking Institution or Branch where Account is maintained

As a convenience to me, I authorize you to pay and to charge my account checks, share drafts, electronic fund transfer debits or other account debits made upon my account by and payable to the order of Sons of Norway.

I agree that your treatment of each check, share draft or debit, and your rights with respect to it will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason you will not be under any liability even though dishonor results in forfeiture of insurance.

I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation unless you end it earlier.

Signature of Depositor

Additional Signature (If joint account)

Date

INCLUDE A VOIDED "SAMPLE" CHECK WITH THIS AUTHORIZATION

Deduct on the First ☐ Fifteenth ☐

19 Additional Information

Home Office Corrections/additions (registrar's initials)

DECLARATIONS BY ALL PROPOSED INSUREDS

I/We Represent that all statements and answers made in all parts of this application are full, complete and true to the best of our 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 or medical examiner 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(s) is (are) alive and in the same condition of health as described in this application when the certificate is delivered to the owner and the full first premium is paid. However, if the full first premium is paid as set forth in the conditional receipt and this receipt is delivered to the owner, the terms of this receipt shall apply.

4. Acceptance of a certificate by the owner shall constitute ratification of any changes made by Sons of Norway under "Home Office Corrections". In those jurisdictions where it is required, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the owner's written consent.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, employer, consumer reporting agency, and the Medical Information Bureau, Inc. to give to Sons of Norway or its reinsurers, any and all information available regarding the diagnosis, treatment and prognosis of any physical or mental condition about me. This authorization shall extend to any such information relating to any children to be insured under this application.

I UNDERSTAND the information obtained by use of this authorization will be used by Sons of Norway to determine eligibility for insurance and/or eligibility for benefits under an existing certificate. I AUTHORIZE Sons of Norway or its reinsurer to make a brief report of my personal health information to MIB. Any information obtained by Sons of Norway will not be released to any person or organization EXCEPT to MIB, reinsurance companies, or other persons or organizations performing business or legal services in connection with my application or claim. I KNOW that I may request a copy of the authorization. I AGREE that a copy of the authorization shall be as valid as the original. I ACKNOWLEDGE receipt of and understand the Fair Credit Report and Medical Information Bureau notices. I AGREE this authorization shall be valid for two years from the date shown.

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 (if age 16 or over)		Date signed
X _____		_____
Signature of other insured (if coverage applied for)		Date signed
X _____		_____
Signature of applicant/owner (if other than proposed insured)		Date signed
X _____	_____	_____
Witnessed by representative	Rep number	City and state where signed
		_____
		Representative license #

SONS OF NORWAY

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

• This form complies with the HIPAA Privacy Rule. •

I authorize any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, employer, consumer reporting agency, and the MIB to give to Sons of Norway or its reinsurers, any and all information available regarding the diagnosis, treatment and prognosis of any physical or mental condition about me. This authorization shall extend to any such information relating to any children to be insured under this application.

I understand that my health record may include information pertaining to the treatment of drugs and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases or tuberculosis.

I understand the information obtained by use of this authorization will be used by Sons of Norway to determine eligibility for insurance and/or eligibility for benefits under an existing certificate. I authorize Sons of Norway or its reinsurer to make a brief report of my personal health information to MIB. Any information obtained by Sons of Norway will not be released to any person or organization except to MIB, reinsurance companies, or other persons or organizations performing business or legal services in connection with my application or claim. I agree that a copy of the authorization shall be as valid as the original. I acknowledge receipt of and understand the fair credit report and medical information bureau notices. I agree that this authorization shall remain valid for two years from the date shown below.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation may be in writing and addressed to the privacy officer at Sons of Norway, 1455 West Lake Street, Minneapolis, MN 55408. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary and that if I have questions about disclosure of my health information, I may contact the privacy officer at Sons of Norway and request a copy of this authorization.

Signature of Proposed Insured (if age 16 or over) _____ Date Signed _____

Signature of Parent/Guardian (if proposed insured is under age 16) _____ Date Signed _____

Witnessed by Representative _____ City and State Where Signed _____

REPRESENTATIVE'S REPORT

SONS OF NORWAY

YES	NO	
		1. How long have you known the proposed insured? _____ years.
☐	☐	2. Did you personally interview the proposed insured(s) and complete the application in their presence?
☐	☐	3. From your knowledge and/or observation, are you confident that all information having a bearing on the insurability of the proposed insured(s) has been disclosed in this application?
☐	☐	4. Will the proposed coverage replace or change any existing insurance or annuity?
☐	☐	5. If replacement of existing insurance is involved, have you complied with all state requirements?
☐	☐	6. If any proposed insured is a juvenile (ages 0-15) a. Does child live with parents? b. Amount of life insurance applied for or in force on family members.

Mother $_____ Father $_____

Sibling(s) $_____

Provide explanations to numbers 2, 3 & 5 if no; number 4 if yes.

Continued on page 10

Life App 08-NV

RECEIPT AND CONDITIONAL INSURANCE AGREEMENT

SONS OF NORWAY

1455 West Lake Street
Minneapolis, MN 55408
Toll Free (800) 945-8851

IMPORTANT- READ CAREFULLY

The insurance certificate you have applied for will not become effective unless and until a certificate is delivered to you and you accept it. However, if you have paid us the first premium according to the mode of payment selected *(two months for AWP)*, we will provide the following conditional insurance subject to the exact terms of this receipt. In no event will any conditional insurance ever be in force unless the proposed insured is a standard risk under our underwriting rules.

CONDITIONAL INSURANCE

Conditional insurance is provided for each proposed insured or covered person on the terms and conditions of the type of insurance plan applied for if:

1. The application and all medical examinations required by our published underwriting rules have been completed; and
2. All representations made in the application are true and complete and;
3. The proposed insured is acceptable as a standard risk under our underwriting rules for the plan and amount of insurance applied for.
4. The proposed insured dies as the result of any cause other than suicide; and
5. This agreement has not terminated.

The amount of insurance becoming effective under the terms and conditions of this conditional receipt is limited to the lesser of:

1. The amount applied for in the application; or
2. $250,000 of life insurance (including any benefits payable as a result of the accidental death of the proposed insured).

Conditional insurance coverage begins on the latest of the following dates:

1. The date of this application.
2. The date of completion of all medical examinations required by our published underwriting rules; or
3. Any other date you may have requested in this application.

Continued on page 10

YOUR RIGHT TO MAKE CORRECTIONS OF FILE INFORMATION

If you feel our information may be incorrect or incomplete, you may ask us to review it. If we agree to make a change, we will change the file to show the correction or addition. Also, we will inform anyone else to whom we have disclosed the original information of this correction. Even if we do not agree to make any changes, you still may file a statement with us stating what you believe is the correct information. We will then send your statement to anyone to whom we sent the information in the past and include it in any future disclosures.

THE MEDICAL INFORMATION BUREAU, INC. (MIB)

Information regarding your insurability will be treated as confidential. Sons of Norway, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly know 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 your 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.

Sons of Norway, 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.

CONSUMER REPORTS

An investigative consumer report may be requested to help us determine your insurability. This report would include information on your lifestyle, character, general reputation and personal characteristics such as health, occupation and finances. The consumer reporting agency would gather this information through interviews with you, your family, business associates, friends and financial institutions. You have the right, upon written request, to be informed if an investigative consumer report was made. If a report was made, we will give you the name and address of the consumer reporting agency, which you can then contact. The agency will let you review and receive a copy of the report and also explain their retention and release practices.

FURTHER INFORMATION

Your Sons of Norway representative will be happy to answer any questions you might have. You may write to Sons of Norway at 1455 West Lake Street, Minneapolis, MN 55408.

SONS OF NORWAY

Protecting Your Privacy!

NOTICE OF INFORMATION PRACTICES, CONSUMER REPORTS, AND MEDICAL INFORMATION BUREAU, INC.

Thank you for your confidence in Sons of Norway as evidenced by your application for insurance. We are proud to provide our members with insurance protection at a reasonable cost. To enable us to offer reasonable premiums and to determine eligibility for coverage, our Underwriting department evaluates each insurance application. The following information describes some important features of our underwriting practices.

SOURCES OF INFORMATION

The application for insurance is our major source of information. Sometimes it is necessary that we verify or secure more information in addition to what you provided us. At our expense, we may obtain this information by correspondence, telephone or personal contact. We may ask you to take a physical exam or have a special medical test done such as an electrocardiogram. Also, we might write to your doctor or to any medical source from which you may have received care. We may obtain information from the Medical Information Bureau and/or a consumer reporting agency. (We will explain more about these organizations later.) We might contact other insurance or reinsurance companies to help us properly evaluate your application. Furthermore, your Sons of Norway representative may ask you questions to help evaluate your insurance program.

PROTECTING YOUR PRIVACY

We consider the information we gather about you to be confidential and we obtain it only in order to establish your insurability. However, there will be some rare occasions where we would furnish information without your consent. For example, a state insurance department or law enforcement agency might request information as part of their regulatory or enforcement duties. Or, if we were to discover a medical condition of which you were unaware, we may inform your physician.

Information on you may be used for statistical purposes or marketing research, but you would not be identified individually. Also, it may be necessary to provide information to certain industry-support organizations to allow them to perform their functions. An example would be a consumer reporting agency that may need some basic identifying data in order to collect information that is needed to evaluate your application or process your claim.

I HAVE ARRANGED FOR THE FOLLOWING *(CHECK ALL THAT APPLY)*

☐ EXAM BY: ☐ SPECIMEN ☐ BLOOD PROFILE ☐ EKG ☐ OTHER

PROPOSED INSURED IS A

☐ NEW CLIENT ☐ REPEAT BUYER

PROPOSED INSURED'S EDUCATION

☐ HIGH SCHOOL OR LESS ☐ SOME COLLEGE ☐ COLLEGE GRAD ☐ GRADUATE DEGREE ☐ UNKNOWN

OCCUPATION ☐ SALES ☐ CLERICAL ☐ CRAFTSMEN/TRADESMEN ☐ HOMEMAKER ☐ JUVENILE

☐ PROFESSIONAL/MANAGERIAL ☐ PERSONAL SERVICES ☐ STUDENT OVER 15 ☐ OTHER:

PURPOSE FOR INSURANCE

☐ PERSONAL ☐ BUSINESS ☐ ESTATE ☐ OTHER:

SALES PRESENTATION

☐ SINGLE NEED ☐ PROGRAMMING ☐ SAVINGS ☐ BUSINESS ☐ ESTATE ☐ OTHER:

SOURCE OF APPLICANT ☐ REFERRED LEAD ☐ LEAD LETTER REPLY ☐ RELATIVE ☐ PREMIUM STUFFER/VIKING MAGAZINE

☐ AGENTS' OWN CERT. HOLDER ☐ ACQUAINTANCE ☐ BOOTH DISPLAY ☐ ORPHAN CERT. HOLDER ☐ OTHER:

REMARKS:

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. I FURTHER CERTIFY THAT I GAVE EACH PROPOSED INSURED THE CONSUMER INFORMATION NOTICES ALONG WITH ALL OTHER REQUIREMENTS OF THE JURISDICTION IN WHICH THE APPLICATION WAS WRITTEN. ALSO, I CERTIFY THAT THE INSURANCE APPLICATION IS NOT INTENDED TO REPLACE OR CHANGE ANY INSURANCE EXCEPT AS INDICATED.

SIGNATURE OF REPRESENTATIVE	DATE SIGNED
X	

TERMINATION OF CONDITIONAL INSURANCE

THIS AGREEMENT WILL TERMINATE ON THE EARLIEST OF

1. THE DATE WE REFUND YOUR PREMIUM PAYMENT; OR
2. NOTIFY YOU THAT WE HAVE REJECTED YOUR APPLICATION FOR INSURANCE; OR
3. THE DATE WE ISSUE A CERTIFICATE OF INSURANCE; OR
4. 90 DAYS FROM THE DATE OF THIS APPLICATION.

OTHER CONDITIONS

NO SONS OF NORWAY REPRESENTATIVE CAN DETERMINE THE INSURABILITY OF ANY PROPOSED INSURED OR BIND US BY MAKING ANY PROMISE OR REPRESENTATION OTHER THAN AS CONTAINED IN THIS AGREEMENT. WE MAKE THIS AGREEMENT IN CONSIDERATION OF RECEIVING THE FIRST FULL PREMIUM PAYMENT FOR THE MODE OF PAYMENT SELECTED. WE WILL REFUND YOUR PREMIUM PAYMENT UNLESS YOU ACCEPT DELIVERY OF THE CERTIFICATE WE OFFER OR UNLESS WE PAY A CLAIM UNDER THIS AGREEMENT.

ALL PREMIUM CHECKS MUST BE PAYABLE TO SONS OF NORWAY. DO NOT MAKE CHECKS PAYABLE TO THE REPRESENTATIVE OR LEAVE THE PAYEE BLANK.

I UNDERSTAND AND AGREE TO ALL THE TERMS AND CONDITIONS STATED.

NAME OF PROPOSED INSURED *(PLEASE PRINT)*	DATE OF RECEIPT	$ AMOUNT RECEIVED
X SIGNATURE OF PROPOSED INSURED	SIGNATURE OF OTHER INSURED *(IF REQUIRED)*	DATE SIGNED
X SIGNATURE OF APPLICANT/OWNER *(IF OTHER THAN PROPOSED INSURED)*		DATE SIGNED
X SIGNATURE OF REPRESENTATIVE	( ) REPRESENTATIVE'S TELEPHONE	DATE SIGNED