Individual Single Premium Life Insurance Application

SONS OF NORWAY
1455 West Lake Street
Minneapolis, MN 55408-2666
Phone (612) 827-3611
Toll Free (800) 945-8851
www.sonsofnorway.com

Maximum amount: $24,999 for issue ages 0-59
$9,999 for issue ages 60-85

1 Proposed Insured - 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)

Height | Weight | Occupation

2 Applicant/Owner - if other than the Proposed Insured (Owner must sign Page 3)

Current Sons of Norway Member? ☐ yes ☐ no

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 w/ Application	Premium w/ Application
$	$	$	$

Underwriting Class: ☐ Std Non-Tobacco ☐ Tobacco ☐ Juvenile (age 0-17)

Is the proposed insured currently using or has used in the past 12 months any form of tobacco or nicotine substitute? ☐ yes ☐ no

Dividend Option: ☐ Cash ☐ Paid-up Addition ☐ Accumulate at Interest

4 Life Insurance in Force: If none, so state. *(If insured is under age 16, include amounts currently in force on owner.)*

Use number 6 if additional space is needed.

Company	Policy Number	Replace or Change	Coverage Amount

Regarding all Persons Proposed for Insurance:

(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)..... ☐ yes ☐ no

(b) Does any person proposed for insurance have an application pending with another company?
(If "Yes", give Person, Company and Amount in #6 below.)..... ☐ yes ☐ no

5 To Be Completed by Proposed Insured. To the best of your knowledge and belief:

1. In the last 5 years have you been treated, examined or advised by a member of the medical profession for any of the following:

a) cancer or any cancer-related disease or tumor? ☐ YES ☐ NO

b) atrial fibrillation, cardiac pacemaker, heart attack, heart valve impairment/replacement, bypass surgery, congestive heart failure, stroke? ☐ YES ☐ NO

c) cirrhosis, hepatitis (chronic or type B or C), chronic disease of the liver or kidneys? ☐ YES ☐ NO

d) alcohol abuse and/or addiction, drug abuse and/or addiction? ☐ YES ☐ NO

e) Alzheimer's disease, Down's syndrome, psychotic disorders, chronic obstructive pulmonary disease, organ transplant? ☐ YES ☐ NO

2. In the last 5 years have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex)? ☐ YES ☐ NO

3. In the last 5 years have you been treated, examined or advised by a member of the medical profession to obtain specified medical care which has yet to be completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus? ☐ YES ☐ NO

If yes, list condition or illness: _____

6 Details to sections 4 and 5. *(An additional sheet of paper may be attached, if necessary.)*

Person	Question	Date of Event	Details

7 Beneficiary

Primary Beneficiary:	Relationship:
Contingent Beneficiary:	Relationship:

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 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 is alive and in the same condition of health as described in this application when the certificate is delivered to the owner and the full premium is received in Sons of Norway Headquarters.
4. Acceptance of a certificate by the owner shall constitute ratification of any changes made by Sons of Norway. 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 the authorization will be used by Sons of Norway to determine eligibility for insurance and/or eligibility for benefits under an existing certificate. Any information obtained will not be released by Sons of Norway to any person or organization EXCEPT to reinsurance companies, Medical Information Bureau, Inc., (MIB) 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 photocopy of the authorization shall be as valid as the original. I AGREE this authorization shall be valid for two years from the date shown below.

X_____ _____

Signature of proposed insured (if age 16 or over) 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.

X_____ _____ _____

Witnessed by financial benefits counselor FBC number Date signed

_____ _____

City and state where signed FBC 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 _____