

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

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	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> 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 Secondary Addressee

For the purpose of notification of a past due premium payment and possible lapse in coverage.

I choose to: Not name a secondary addressee Name a secondary addressee

Print name of secondary addressee (first, middle initial, last)

Address City State Zip (country if not USA)

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 and with intent to injure, defraud, or deceive any insurer files a statement or claim or an application containing any false, incomplete, or missing information is guilty of a felony of the third degree.

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 _____ **X** _____
 Agent Name (please print) Signature of Agent

 Agent number Agent Florida License Number Date signed