Individual Simplified Issue
Life Insurance Application

SONS of NORWAY
1455 West Lake Street
Minneapolis, MN 55408-2666
Toll-free: 833-707-0012
Fax: 612-827-0658
www.sonsofnorway.com

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

Full Name (include middle initial) | Birth Date | State of Birth | Marital Status | Sex

Social Security No. | Driver's License No. & State | Driver's License Exp Date | Best Contact Phone No.

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

Height | Weight | Annual Income | Net Worth

Occupation

2 ☐ Applicant/Owner – if other than the Proposed Insured (Owner must sign Page 4)

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)

Best Contact Phone No.

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

3 Insurance Applied For – ☐ WL ☐ SPWL ☐ Juvenile Term Term ☐ 10 ☐ 15 ☐ 20 ☐ 30 ☐ Other _____

Amount	Premium	Premium Mode		Premium w/App	Dues w/App (if owner differs from insured)
$	$	☐ Monthly EFT ☐ Quarterly	☐ Semi-Ann ☐ Annual ☐ Single	$	$

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: ☐ Paid-up Addition ☐ Reduce Premium ☐ Cash ☐ Accumulate at Interest

Optional Riders

☐ Guaranteed Purchase Option $_____ ☐ Childrens Insurance Rider $_____ (provide details below)

Name(s) of children	Age	Birthdate	Social Security Number	Birthplace

4 Life Insurance in Force –

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, indicate which policy in chart below and complete all required state forms.)..... ☐ Yes ☐ No

Company	Policy Number	Replace or Change	Coverage Amount

5 Regarding Person Proposed for Insurance:

a) Does the person proposed for insurance have an application pending with another company?
(If Yes, give details below.)..... ☐ Yes ☐ No

b) Has the person proposed for insurance ever been rated up, declined or postponed for life or health insurance coverage? (If Yes, give details below.)..... ☐ Yes ☐ No

6 To Be Completed by Proposed Insured – To the best of your knowledge and belief:

(If any of the following questions are answered yes, provide details of condition, illness, or prescription in Section 7.)

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) high blood pressure, diabetes or high blood sugar? ..... ☐ YES ☐ NO

b) atrial fibrillation, cardiac pacemaker, heart attack, heart valve disorder/replacement, cardiac bypass surgery, congestive heart failure, coronary artery disease (CAD), stroke, TIA? ..... ☐ YES ☐ NO

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

d) cancer, tumor or disorder of the lymph nodes?..... ☐ YES ☐ NO

e) alcohol abuse and/or addiction, drug abuse and/or addiction, chronic pain or patient in pain clinic? .... ☐ YES ☐ NO

f) cognative or mental disorders such as Alzheimer's disease, dementia, Down's syndrome, psychotic disorders, anxiety, or depression?..... ☐ YES ☐ NO

g) disorder of the nervous system such as Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS) or Parkinson's?..... ☐ YES ☐ NO

h) chronic obstructive pulmonary disease (COPD), emphysema, asthma, chronic brochitis or sleep apnea? ☐ YES ☐ NO

i) Crohn's disease or ulcerative colitis? ..... ☐ YES ☐ NO

2. Have you been convicted of a felony, misdemeanor or been on probation within the last 10 years? ..... ☐ YES ☐ NO

3. Are you currently taking any prescribed medications (please include a description of "why prescribed" below)? ..... ☐ YES ☐ NO

7 Details to question 5 and 6

Question	Date of Event	Details

8 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

9 Telephone Interview

Sons of Norway and its service partners, including ExamOne World Wide, use technology that includes automated telephone dialing systems and prerecorded messages (automated technology) to improve the application process. I understand I am not required to provide consent to use this automated technology as a condition of completing the application or process of purchasing insurance or other products from Sons of Norway. If specified below I consent to the parties indicated above contacting me at any of the phone numbers I have provided, including cell phones, using automated technology.

☐ I consent to the parties indicated above contacting me using automated technology

10 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 _____ (1st-28th) of the month.

If in good order, process application ☐ immediately or ☐ hold until requested draw date

Name of bank account owner: _____

Home 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

11 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 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, pharmacy benefit manager, other medical or medically related facility, insurance company, employer, consumer reporting agency, department of motor vehicles and the Medical Information Bureau (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 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, Department of Motor Vehicles, reinsurance companies, or other persons or organizations performing business or legal services in connection with my application or claim. I understand that any disclosure of information may be subject to re-disclosure and may no longer be protected by federal or state law.

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 acknowledge receipt of and understand the MIB notice. I agree this authorization shall be valid for two years from the date shown below. The time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.

I UNDERSTAND that I have the right to revoke this authorization at any time by writing to the Company at the address provided in this application.

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

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. I certify that the insurance application is not intended to replace or change any insurance except as indicated. I also understand that if the application for this insurance product is declined for any reason, my client may elect to obtain the Guaranteed Solution Whole Life product, up to the product face amount maximum, without an additional application. An amendment to this certificate would be required at the time of issue.

X_____ _____ _____

Agent Signature Florida License # If in good order, process application ☐

_____ _____

City and State where signed Agent #