WCU FINANCIAL
ESTABLISHED IN 1877
FAITH | STRENGTH | SECURITY

Western Catholic Union
A Fraternal Benefit Society
510 Maine St, Quincy, IL 62301
217-223-9721 • Fax: 217-223-9726
www.wculife.org

# JUVENILE TERM LIFE APPLICATION CHECKLIST
# CO, IL, IA, MD, MO, PA, TX, WV & WI

**Issue Ages 0-18 • Face Amount $10,000 or $20,000**

## REQUIRED FOR ALL APPLICATIONS:

☐ Application for Individual Single Premium Term Life Insurance to Age 25

## REQUIRED IF PAYING PREMIUM BY ONE-TIME BANK DRAFT:

☐ Electronic Premium Payment Authorization

## OTHER FORMS THAT MAY BE NEEDED:

***AVAILABLE ON THE AGENT FORMS PAGE AT WCULIFE.ORG OR IN THE AGENT PORTAL***

Additional Beneficiaries

Conditional Receipt

## NOTES FOR THE HOME OFFICE:

_____

_____

_____

_____

WCU FINANCIAL
ESTABLISHED IN 1877
FAITH | STRENGTH | SECURITY

Western Catholic Union
A Fraternal Benefit Society
510 Maine St, Quincy, IL 62301
217-223-9721 • Fax: 217-223-9726
www.wculife.org

# APPLICATION FOR INDIVIDUAL SINGLE PREMIUM TERM LIFE INSURANCE TO AGE 25

## CHILD TO BE INSURED

Child to be Insured (First Name, Middle Initial, Last Name): _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Birth Sex: ☐ Male ☐ Female

Street Address, City, State, Zip + 4 Code: _____

Coverage Amount Requested: ☐ $10,000 for $125 single premium ☐ $20,000 for $250 single premium

## PAYOR

Payor (First Name, Middle Initial, Last Name): _____

Social Security Number: _____ Date of Birth: _____ Relationship to Child: _____

Street Address, City, State, Zip + 4 Code: _____

Home Phone Number: _____ Email Address: _____

## OWNER

Owner (First Name, Middle Initial, Last Name): _____

Social Security Number: _____ Date of Birth: _____ Relationship to Child: _____

Street Address, City, State, Zip + 4 Code: _____

Home Phone Number: _____ Email Address: _____

## CONTINGENT OWNER (Not required)

Contingent Owner (First Name, Middle Initial, Last Name): _____

Social Security Number: _____ Date of Birth: _____ Relationship to Child: _____

Street Address, City, State, Zip + 4 Code: _____

Home Phone Number: _____ Email Address: _____

## BENEFICIARY DESIGNATION (If more than one beneficiary is named, proceeds will be divided equally unless you indicate a share.)

**Primary** Beneficiary Name | Relationship to Insured | Social Security # | Date of Birth | Share

Address | City | State | Zip + 4 Code

**Primary** Beneficiary Name | Relationship to Insured | Social Security # | Date of Birth | Share

Address | City | State | Zip + 4 Code

**Contingent** Beneficiary Name | Relationship to Insured | Social Security # | Date of Birth | Share

Address | City | State | Zip + 4 Code

**Contingent** Beneficiary Name | Relationship to Insured | Social Security # | Date of Birth | Share

Address | City | State | Zip + 4 Code

## REPLACEMENT

1. Does the child to be insured have existing life insurance policies or annuity contracts in force with this or any other company? ☐ Yes ☐ No
2. Is the insurance applied for intended to replace or change any existing life insurance policy or annuity with this or any other company? ☐ Yes ☐ No
   a. If yes, furnish insurance company's name and address and the policy number to be replaced. _____

## STATEMENT OF HEALTH **(Please check Yes or No for all 3 questions.)**

1. Has the child to be insured ever received diagnosis, treatment or medical advice from a member of the medical profession for birth defects, heart or circulatory disease, diabetes, psychiatric treatment or mental illness? ☐ Yes ☐ No
2. Has the child to be insured ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus? ☐ Yes ☐ No
3. In the past 3 years has the child to be insured received diagnosis, treatment or medical advice from a member of the medical profession for any reason other than routine pediatric examinations, school physicals, immunizations or treatment for childhood diseases (excluding diagnostic tests related to the Human Immunodeficiency Virus)? ☐ Yes ☐ No
4. Please give complete details to any "yes" answers. _____

## PLEASE READ AND SIGN

I am the parent, grandparent or legal guardian, I have read the questions and answers written in this application, and the statements and answers are true and complete to the best of my knowledge and belief. I agree that this application will be the basis for any certificate issued on this application. I further agree that this insurance applied for shall be subject to the conditions and provisions of the contract of insurance and shall not be in force until the application is accepted and the contract of insurance issued by Western Catholic Union. I agree, for myself, the child to be insured and any beneficiary(ies), to abide by the Articles of Incorporation and Bylaws of Western Catholic Union. I have attached a check payable to Western Catholic Union for the premium.

## FRAUD WARNING NOTICE

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.

WESTERN CATHOLIC UNION IS LICENSED TO DO BUSINESS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN ANY STATE'S 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.

Signed: _____ at _____
(Month, Day, Year) (City, State)

Witnessed by: _____ _____
Signature of Western Catholic Union Licensed Representative | Printed Name of Representative & Representative Number

_____ _____
Signature of Member/Applicant (Parent, Grandparent or Legal Guardian) | Printed Name of Member/Applicant

_____ _____
Signature of Owner (If other than Member/Applicant) | Title of Owner

## REPRESENTATIVE'S STATEMENT

1. Does the child to be insured have existing life insurance policies or annuity contracts in force? ..... ☐ Yes ☐ No

2. Is the insurance applied for intended to replace any other insurance in force?..... ☐ Yes ☐ No

3. Did you personally see the child to be insured at the time of application?..... ☐ Yes ☐ No
   (Explain why not below.)

## ADDITIONAL INFORMATION AND DETAILS

Signature of Western Catholic Union Licensed Representative

Date

WCU FINANCIAL
ESTABLISHED IN 1877
FAITH | STRENGTH | SECURITY

Western Catholic Union
A Fraternal Benefit Society
510 Maine St, Quincy, IL 62301
217-223-9721 • Fax: 217-223-9726
www.wculife.org

# ELECTRONIC PREMIUM PAYMENT AUTHORIZATION

## INFORMATION

Annuitant/Insured: _____

Owner (if other than annuitant/insured): _____

## INSTRUCTIONS

Withdraw premium **ONE-TIME ONLY** on date of issue.

## BANK INFORMATION

Amount: $_____

Account Type: ☐ Checking (include voided check – no deposit slips) ☐ Savings

**IF VOIDED CHECK IS NOT PROVIDED, OR SAVINGS IS SELECTED, COMPLETE BANK INFO**

Name on Bank Account: _____

Name of Financial Institution: _____

Address of Financial Institution: _____

Routing #: _____ Account #: _____

**BANK AUTHORIZATION**

- I hereby authorize Western Catholic Union (WCU) to withdraw the amount listed above by initiating a one-time debit entry from my account at the financial institution indicated above. In the event of a transactional error, I authorize WCU to make a correcting credit/debit entry to my account.
- Certificate Owner is responsible for the accuracy of the payment information.

Signature of Bank Account Holder: _____ Date: _____

## SIGNATURE

Owner: _____ Date: _____

**AFFIX VOIDED CHECK HERE**