WCU FINANCIAL
ESTABLISHED IN 1877
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Western Catholic Union
A Fraternal Benefit Society
510 Maine St, Quincy, IL 62301
217-223-9721 • Fax: 217-223-9726
www.wculife.org

# WHOLE LIFE APPLICATION CHECKLIST
# ILLINOIS

## REQUIRED FOR ALL APPLICATIONS:

- ☐ Application for Individual Whole Life Insurance
- ☐ MIB Pre-Notice
- ☐ MIB Authorization
- ☐ HIPAA Compliant Authorization

## REQUIRED IF PAYING PREMIUMS BY MONTHLY BANK DRAFT:

- ☐ Automatic Premium Payment Authorization

## REQUIRED IF FUNDS ARE COMING FROM ANOTHER LIFE POLICY:

- ☐ Authorization to Transfer Funds
- ☐ Replacement of Annuities or Life Insurance

## REQUIRED IF NO ILLUSTRATION IS SUBMITTED AT TIME OF APPLICATION:

- ☐ Illustration Acknowledgement and Certification

## 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:

_____

_____

_____

_____

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# APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE

Is the Proposed Insured an existing member of Western Catholic Union? ☐ Yes ☐ No
**I understand if my application is approved I am automatically a member of WCU.**

## PROPOSED INSURED

1. Proposed Insured (First Name, Middle Initial, Last Name): _____

2. Date of Birth: _____ 3. Current Age: _____ 4. Birth Sex: ☐ Male ☐ Female

5. Social Security Number: _____ 6. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

7. Birth State, Country: _____ 8. Maiden Name (if applicable): _____

9. Street Address: _____

City: _____ State: _____ Zip + 4 Code: _____

Mailing Address (if different): _____

How Long Here: _____ 10. Email Address: _____

11. Phone: Home: _____ Work: _____

Cell: _____ Best time to call: _____ ☐ AM ☐ PM

12. Net Worth: _____ 13. Driver's License Number: _____ State of Issue: _____

14. Occupation: _____ 15. Annual Income: _____

## SELECTION OF COVERAGE

1. Tobacco Use ☐ Non-tobacco ☐ Tobacco
2. Whole Life Plan ☐ Lifetime Pay ☐ 10 Pay ☐ 20 Pay ☐ Single Pay
3. Dividend Option ☐ Purchase Additional Paid-Up ☐ Pay In Cash
4. Include Automatic Premium Loan ☐ Yes ☐ No

5. Face Amount
$_____

6. Base Premium Amount
$_____

7. Amount Remitted
$_____

| 8. Riders | 9. Rider Face Amount | 10. Rider Premium |
|---|---|---|
| ☐ Accidental Death Benefit Rider | | |
| ☐ Waiver of Premium Rider | | |
| ☐ Paid-Up Additions Rider - Single Pay | | |

11. Total Premium (Base Premium Amount + Rider Premium(s)) $_____

12. Premium Mode ☐ Monthly (bank draft only) ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Single Premium
13. Billing Method ☐ Bank Draft ☐ Direct

## REPLACEMENT

1. Does the Proposed Insured have existing life insurance policies or annuity contracts in force with this or any other company? ☐ Yes ☐ No
   a. If "Yes," amount of life insurance in force. _____
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 or changed.

_____

## OWNER AND/OR PAYOR (IF OTHER THAN PROPOSED INSURED)

1. Check all that apply: ☐ Owner ☐ Payor

Full Legal Name: _____ Social Security Number: _____

Address: _____

Date of Birth: _____ Relationship to Proposed Insured: _____

Phone Number: _____ Email Address: _____

Annual Income: _____ Net Worth: _____

2. Is Proposed Insured a Juvenile (age 15 days – 17 years)? ☐ Yes ☐ No
   (a) If "Yes," please give amount of insurance in force on Parent/Legal Guardian: _____
   (b) If "Yes," annual income of Parent/Legal Guardian: _____
   (c) If "Yes," is each other child in the family insured or to be insured concurrently for an amount at least equal to that on the Proposed Insured? ☐ Yes ☐ No
      a. If "No," explain why not. _____

| (d) **Names of all siblings (If Proposed Insured is the only child put "None")** | **Sibling's amount of insurance in force** |
|---|---|
| | |
| | |
| | |
| | |
| | |

   (e) Complete if Proposed Insured is age 24 months and younger:
      a. Was the child born prematurely (less than 37 weeks gestation)? ☐ Yes ☐ No
      b. Was the child's birth weight less than 5 pounds (2.27 kilograms)? ☐ Yes ☐ No
      c. Has the child required hospitalization or been diagnosed by a member of the medical profession for:
         (a) Hospitalization ☐ Yes ☐ No
         (b) Birth Injury ☐ Yes ☐ No
         (c) Congenital Disorder ☐ Yes ☐ No
         (d) Deformity ☐ Yes ☐ No
         (e) Heart Defect ☐ Yes ☐ No
         (f) Development Delay ☐ Yes ☐ No
         (g) Intellectual Disability ☐ Yes ☐ No
         (h) Accidental Injury ☐ Yes ☐ No

## DECLARATION OF INSURABILITY

**Give complete details of all "Yes" answers for questions 5 - 9, including dates, in #10.**

1. Current Height: _____ Current Weight: _____

   If weight gain or lost in past year is more than 10 pounds, please explain the details or choices about the weight change:

   _____

2. Has the Proposed Insured used any form of tobacco or nicotine replacement products in the last 12 months? ☐ Yes ☐ No

   Type of tobacco used (i.e. cigarettes, pipe, smokeless tobacco, cigar, vape): _____ Date last used: _____

3. Has the Proposed Insured used any form of marijuana/THC products in the last 12 months? ☐ Yes ☐ No

   Type(s) used (i.e. edible, flower, vape, concentrates): _____ Frequency: _____

4. Personal physician or medical facility where medical records can be obtained. Indicate if none.

   Physician/Facility: _____ Phone Number: _____

   Address: _____

   Date last consulted: _____ Reason: _____

   Findings, treatment given, and medication prescribed: _____

5. Has the Proposed Insured:

   (a) Ever had an application for life or health insurance declined, postponed, modified, or rated for extra premium? ☐ Yes ☐ No

      a. If "Yes," please give date, name of company and reason: _____

      _____

   (b) Flown as a pilot, co-pilot, student pilot, or crew member in the last 3 years? ☐ Yes ☐ No

   (c) Participated in any of the following in the last 3 years:

      a. Motor sports events or racing (auto, truck, cycle, boat, snowmobile, etc.) on land or water? ☐ Yes ☐ No

      b. Underwater diving or use of a submarine? ☐ Yes ☐ No

      c. Sky diving, parachuting, paraskiing or parakiting? ☐ Yes ☐ No

      d. Heli-skiing or Heli-snowboarding? ☐ Yes ☐ No

      e. Mountain, rock or ice climbing? ☐ Yes ☐ No

      f. Base or bungee jumping? ☐ Yes ☐ No

      g. Competitive skiing, including water speed record attempts, snowboarding or luging? ☐ Yes ☐ No

      h. Competitive boxing, wrestling or mixed martial arts? ☐ Yes ☐ No

      i. Big game hunting? ☐ Yes ☐ No

      j. Rodeo or equine sports? ☐ Yes ☐ No

      k. Aerial sports? ☐ Yes ☐ No

   (d) In the last 10 years had a driver's license suspended, revoked, plead guilty to or been convicted of Driving Under the Influence? ☐ Yes ☐ No

   (e) In the last 5 years had a driver's license suspended, revoked, or plead guilty to or been convicted of any moving traffic violation? ☐ Yes ☐ No

## DECLARATION OF INSURABILITY (CONTINUED)

(f) In the last 10 years, have you:

a. Pled guilty to or been convicted of a felony? ☐ Yes ☐ No

b. Been on parole or probation? ☐ Yes ☐ No

c. Do you currently have any criminal charges pending? ☐ Yes ☐ No

6. Does the Proposed Insured consume alcohol? ☐ Yes ☐ No

(a) If "Yes," state number of drinks per sitting and number of days per week alcohol is consumed: _____

7. Has the Proposed Insured ever been treated for or advised to have treatment for alcohol abuse/alcoholism by a member of the medical profession? ☐ Yes ☐ No

8. Other than as prescribed by a physician, in the last 10 years have you used:

(a) Amphetamines ☐ Yes ☐ No

(b) Barbiturates ☐ Yes ☐ No

(c) Cocaine ☐ Yes ☐ No

(d) Hallucinogens ☐ Yes ☐ No

(e) Heroin ☐ Yes ☐ No

(f) Narcotics ☐ Yes ☐ No

(g) Opioids ☐ Yes ☐ No

(h) Prescription medications in excess of prescribed dosages ☐ Yes ☐ No

(i) Stimulants ☐ Yes ☐ No

(j) Other illegal drugs or substances (If "Yes, specify below) ☐ Yes ☐ No

(k) Have you ever sought, been advised to seek or received counseling or treatment for the use of drugs, including prescribed controlled substances, from a licensed health professional or support group? ☐ Yes ☐ No

9. Has the Proposed Insured traveled or resided outside the U.S. in the past 2 years or have any plans to travel or reside outside the United States in the next 2 years? **(If "Yes," include Dates of Travel, Duration, and Accommodations in #10)** ☐ Yes ☐ No

10. Please give complete details to any "Yes" answers, under Declaration of Insurability, for questions 5 – 9.

## MEDICAL QUESTIONS

**Give complete details of all "Yes" answers, including physician or medical facility name, address, and phone number, in #9.**

1. In the last 10 years, has the Proposed Insured consulted a physician or member of the medical profession for, been diagnosed by a member of the medical profession as having or been treated by a member of the medical profession for:
   - (a) Heart or circulatory disorder? ☐ Yes ☐ No
   - (b) Heart attack, chest pain or angina? ☐ Yes ☐ No
   - (c) Irregular pulse or heart arrhythmia or fibrillation or palpitations? ☐ Yes ☐ No
   - (d) Shortness of breath? ☐ Yes ☐ No
   - (e) Stroke or brain attack (TIA) or aneurysm? ☐ Yes ☐ No
   - (f) High blood pressure or high cholesterol? ☐ Yes ☐ No
   - (g) Artery or vein disorder? ☐ Yes ☐ No
   - (h) Cancer, leukemia, myeloma, lymphoma, or tumor (benign or malignant)? ☐ Yes ☐ No
   - (i) Melanoma or Chronic skin disease? ☐ Yes ☐ No
   - (j) Nodules, masses or cysts? ☐ Yes ☐ No
   - (k) Reproductive system disorder? ☐ Yes ☐ No
   - (l) Kidney or bladder disorder? ☐ Yes ☐ No
   - (m) Sugar, blood, or protein (albumin) in the urine? ☐ Yes ☐ No
   - (n) Esophagus or stomach disorder? ☐ Yes ☐ No
   - (o) Hepatitis, liver, pancreas, or gallbladder disease or disorder? ☐ Yes ☐ No
   - (p) Multiple sclerosis or neurological disorder? ☐ Yes ☐ No
   - (q) Seizures, convulsions, epilepsy or nervous system disorder? ☐ Yes ☐ No
   - (r) Digestive system or intestinal disorder, colitis, or Crohn's disease? ☐ Yes ☐ No
   - (s) Asthma, emphysema, chronic obstructive pulmonary disease COPD, sleep apnea syndrome, or other respiratory or lung disorder? ☐ Yes ☐ No
   - (t) Anemia, blood, or lymph node disorder? ☐ Yes ☐ No
   - (u) Arthritis or back, spine, bone, joint, or muscle disorder? ☐ Yes ☐ No
   - (v) Lupus or other connective tissue disease? ☐ Yes ☐ No
   - (w) Pregnancy complications or disorders? ☐ Yes ☐ No
   - (x) Testicular disease or disorder? ☐ Yes ☐ No
   - (y) Endocrine system, thyroid disorder, or other hormone disorders? ☐ Yes ☐ No
   - (z) Fibromyalgia? ☐ Yes ☐ No
   - (aa) Diabetes? ☐ Yes ☐ No
   - (bb) Sexually transmitted disorders or diseases? ☐ Yes ☐ No

2. Is the Proposed Insured now taking physician-prescribed medication or form of treatment? ☐ Yes ☐ No

3. Has the Proposed Insured consulted a physician or member of the medical profession for, been diagnosed by a member of the medical profession as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS-related conditions? ☐ Yes ☐ No

4. During the past 5 years has the Proposed Insured been advised by a member of the medical profession to have surgery, hospitalization, or a diagnostic test, or any other medical procedure or test which has not yet been started, completed, or for which results are not known (excluding those tests related to the Human Immunodeficiency Virus (AIDS Virus)? ☐ Yes ☐ No

## MEDICAL QUESTIONS (CONTINUED)

5. During the past 10 years has the Proposed Insured consulted a physician or member of the medical profession for, been diagnosed by a member of the medical profession as having or been treated by a member of the medical profession for:
   (a) Depression, Bipolar disorder, Schizophrenia, other mental or nervous disorder? ☐ Yes ☐ No
   (b) Immune deficiency? ☐ Yes ☐ No

6. During the past 5 years, has the Proposed Insured:
   (a) Undergone any operation or surgical procedure? ☐ Yes ☐ No
   (b) Been confined in a hospital or treated, examined, or advised by a member of the medical profession in an emergency medical facility? ☐ Yes ☐ No
   (c) Had any medical test, study or procedure performed (excluding tests related to the Human Immunodeficiency Virus (AIDS virus) by a member of the medical profession ? ☐ Yes ☐ No

7. Does the Proposed Insured use any over-the-counter (non-prescribed) treatments or remedies, such as herbs, dietary supplements, acupuncture, etc.? ☐ Yes ☐ No

8. Is the Proposed Insured now pregnant? ☐ Yes ☐ No
   If "Yes," pre-pregnancy weight? _____ Anticipated due date? _____

9. Please give complete details to any "Yes" answers, under Medical Questions, for questions 1 – 8.

_____

_____

_____

_____

_____

_____

## FAMILY HISTORY

* Please list ALL family members (father, mother, and siblings) names and ages. If any family members have been diagnosed or treated by a member of the medical profession for any condition listed below, please indicate condition in the table. Otherwise, leave "Medical Conditions" column blank for that family member.

**• Cancer • Cardiovascular Disease or Renal (i.e. kidney) Disease • Cerebrovascular Disease (i.e. Stroke) • Diabetes**

| Name | | Living | | Deceased | | |
|---|---|---|---|---|---|---|
| | | Age | Medical Conditions* | Age at Death | Date of Death | Cause of Death |
| Father | | | | | | |
| Mother | | | | | | |
| Siblings (in birth order) | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## BENEFICIARY DESIGNATION

**If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.**

### Primary Beneficiary:

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

Address | City | State | Zip + 4 Code

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

Address | City | State | Zip + 4 Code

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

Address | City | State | Zip + 4 Code

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

Address | City | State | Zip + 4 Code

### Contingent Beneficiary:

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

Address | City | State | Zip + 4 Code

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

Address | City | State | Zip + 4 Code

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

Address | City | State | Zip + 4 Code

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

Address | City | State | Zip + 4 Code

## NOTICE TO PROPOSED INSURED

I understand that in connection with this application for insurance, an investigative consumer report may be made as to my insurability, whereby information may be obtained through interviews with neighbors, friends and associates; and which may include, if applicable, information about character, general reputation, personal characteristics and mode of living. Additional detailed information as to the nature and scope of any investigation will be furnished upon written request.

**Agreements and Authorization -** Records and information obtained will be disclosed to Western Catholic Union for the purpose of evaluating my application for insurance or claim benefits.

Western Catholic Union may release information to the MIB pursuant to this notice. I have read the questions and answers written in this application, and to the best of my knowledge and belief, they are true and complete. I authorize the release of medical or non-medical information to Western Catholic Union from: any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, pharmacy benefit manager, insurance company, MIB, Inc., or other organization, institution, or person which has any records or knowledge of me, or my health, to Western Catholic Union or its reinsurers. I hereby authorize Western Catholic Union to use one of its approved vendors to check my usage of prescription medication. I understand that a telephone interview may be conducted to verify the application.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will be valid for either (1) 24 months; or (2) the maximum period of time permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand I may revoke this Authorization at any time by requesting such of the providing organization in writing at the address shown on this application, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand that I (or my authorized representative) am entitled to a copy of this authorization. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that the 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.

Each of the undersigned declares that the Proposed Insured is eligible for membership under the rules set forth in the Articles of Incorporation and Bylaws of Western Catholic Union.

**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 — Representative Number

_____ _____
Printed Name of Representative — Signature of Owner (If other than Proposed Insured or if Proposed Insured is age 0-17)

_____ _____
Signature of Proposed Insured — Relationship of Owner to Proposed Insured

_____ _____
Signature of Parent/Guardian/Legal Representative (If Proposed Insured is age 0-17) — Owner Social Security Number

## REPRESENTATIVE'S STATEMENT

1. Does the Proposed Insured have existing life insurance policies or annuity contracts in force? ☐ Yes ☐ No
2. Is the insurance applied for intended to replace or change any other insurance in force? ☐ Yes ☐ No
3. Did you personally see the Proposed Insured and ask each question? ☐ Yes ☐ No
   (Explain why not below)

## Additional Information and Details

To the best of my knowledge and belief:

1. I have asked all questions and recorded all answers as they were given to me by the Proposed Insured.
2. I know nothing about the Proposed Insured's health, habits, avocations, or life-style affecting insurability which has not been stated in this application.

Signature of Western Catholic Union Licensed Representative

Date

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# MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Western Catholic Union, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., 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 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. 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.*

Western Catholic Union, 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. For more information about MIB, phone (866) 692-6901 or visit www.mib.com.

**This form MUST be left with the Proposed Insured at time of application.**

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# MIB AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc., or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Western Catholic Union or its reinsurers, any such information. I also authorize Western Catholic Union or its reinsurers to make a brief report of my protected personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. This authorization will be valid for either (1) 24 months; or (2) the maximum period of time permitted by applicable law in the state where the policy is delivered or issued for delivery.

Proposed Insured – **Printed Name**

Proposed Insured/Guardian/ Legal Representative – **Signature**

**Date**

Witness – **Printed Name**

Witness – **Signature**

**Date**

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# HIPAA COMPLIANT AUTHORIZATION

# TO RELEASE HEALTH-RELATED INFORMATION

Print Name of Proposed Insured / Patient

Date of Birth

## AUTHORIZATION

I authorize any physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, pharmacy benefit manager, treatment facility, other medical or medically related facility, the Veterans Administration, and other insurance companies, specifically including those persons/organizations listed above, to give or disclose my entire medical record, to include, but not limited to, patient histories, clinic notes and progress notes, radiology reports, EKG reports, lab reports and pathology reports, prescription drug history, and any other protected health information concerning me for the past 10 years to **Western Catholic Union (WCU)** and it's reinsurer(s). Any and all records and information, including but not limited to, diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

This protected health information is to be disclosed under this authorization so that **Western Catholic Union** may: 1) underwrite my application for coverage, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with **Western Catholic Union.**

I authorize **Western Catholic Union**, its contractor(s) or its reinsurer(s), to make a brief report of my protected personal health information to MIB, Inc. I understand the information released may be subject to re-release by the recipient and no longer be federally protected.

This authorization will be valid for either (1) 24 months; or (2) the maximum period of time 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 in writing, at any time, by sending a written request for revocation to the **WCU** at the address listed above. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the **WCU** has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed, including, but not limited to, other insurance companies and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I further understand that if I refuse to sign this authorization, the **WCU** may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I understand and acknowledge that I or my authorized representative may request a copy of this authorization.

Signature of Proposed Insured / Patient / Guardian / Legal Representative

Date (required)

Social Security Number of Proposed Insured

Agent or Witness Signature

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# AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

## • • NEW LIFE CERTIFICATE • •

**INFORMATION**

Insured: _____

Owner (if other than insured): _____

**OPTIONS (Choose ONE)**

☐ Withdraw premium on date of issue; then on the _____ day each month thereafter.
**(1st – 28th only)**

☐ Withdraw premium on date of issue; then on the same day each month thereafter.

☐ Withdraw premium on the _____ day of each month.
**(1st – 28th only)**

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

**BANK INFORMATION**

Amount: $_____ Account Type: ☐ Checking (attach voided check below – 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 any amounts owed by initiating debit entries from my account at the financial institution indicated above. In the event of a transactional error, I authorize WCU to make correcting credit/debit entries to my account.
- Certificate Owner is responsible for the accuracy of the payment information.
- ACH will remain in effect until terminated by me or WCU upon written notice. **(Does NOT apply to ONE TIME w/d)**

Signature of Bank Account Holder: _____ Date: _____

**SIGNATURE**

Owner: _____ Date: _____

**ATTACH VOIDED CHECK HERE**

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# AUTHORIZATION TO TRANSFER FUNDS

## SURRENDERING COMPANY INFORMATION

Company Name: _____

Address: _____

Phone Number: _____ Approximate Transfer Amount: $_____

Date to complete transfer/surrender: ☐ Immediately ☐ Before _____ ☐ After _____

## ANNUITANT(S) / INSURED / OWNER INFORMATION

Annuitant/Insured: _____ Social Security Number: _____

Address: _____

Joint Annuitant: _____ Social Security Number: _____

Address: _____

Owner (if different): _____ Social Security Number: _____

Address: _____

**The undersigned hereby requests and directs that the following action be taken to transfer the account/policy funds identified below.**

## CERTIFICATE OF DEPOSIT

Account Number: _____

- ☐ Liquidate on the maturity date of ____/____/____.
- ☐ Liquidate upon receipt of this request. I am aware of any penalty that may be imposed from an early withdrawal.
- ☐ Partial Transfer – $_____

## LIQUIDATE (See page 3 for Medallion Stamp Signature Guarantee) – Please select ONLY one

Brokerage Account Number: _____

- ☐ Full Transfer
- ☐ Partial Transfer – $_____ – Number of Shares _____

Mutual Fund(s) Account Number: _____

- ☐ Full Transfer
- ☐ Partial Transfer – $_____

Money Market Account Number: _____

- ☐ Full Transfer
- ☐ Partial Transfer – $_____

401K Pension Plan(s) – May require the company's own paperwork to withdraw. Client must contact their former employer to initiate the transfer.

- ☐ Full Transfer
- ☐ Partial Transfer – $_____

## ANNUITY CONTRACTS

Existing plan: ☐ Non-Qualified Annuity ☐ IRA ☐ Roth IRA ☐ Keogh ☐ SEPP
☐ Converted Roth IRA ☐ TSA ☐ 457 ☐ Other _____

Account Number: _____

☐ **1035 Tax-Free Exchange** – (Please be sure to complete the Absolute Assignment section) – Surrender a non-qualified annuity contract for the purchase of another non-qualified contract under Section 1035 of the Internal Revenue Code.

- ☐ Full Surrender
- ☐ Partial Surrender – $_____
- ☐ Cost Basis Requested: In accordance with the Tax Equity and Fiscal Responsibility Act of 1982, furnish a statement to the Assignee and to the former contract holder of the cost basis in the contract.

☐ **Transfer** – Surrender of qualified annuity contract(s) under Section 402 or 408 of the Internal Revenue Code for reinvestment in a qualified annuity contract established under same section of the Internal Revenue Code.

- ☐ Full Surrender
- ☐ Partial Surrender – $_____

☐ **Surrender** – The undersigned as owner of this contract elects to surrender the said contract for its net cash value and directs the transferring company to make payment(s) to the named Assignee.

- ☐ Full Surrender
- ☐ Partial Surrender – $_____

☐ **TSA/403(b) Transfer** – (TSA to TSA) – This transaction is intended to qualify as a tax-free transfer under Revenue Ruling 90-24.

- ☐ Full Transfer
- ☐ Partial Transfer – $_____

☐ **Direct Transfer** – This amount represents all or part of my eligible rollover distribution. I understand there will be no mandatory 20% withholding from this distribution because it is a direct rollover to an eligible retirement plan as defined under applicable tax law.

- ☐ Full Transfer
- ☐ Partial Transfer – $_____
- ☐ Western Catholic Union contract number is _____.

## LIFE CONTRACTS

**Policy Number:** _____

☐ **Surrender** – The undersigned as owner of this contract elects to surrender the said contract for its net cash value and directs the transferring company to make payment(s) to the named Assignee.

☐ **Surrender entire contract**.

☐ **1035 Tax-Free Exchange** – (Please be sure to complete the Absolute Assignment section) – Surrender a Life Insurance contract for the purchase of another non-qualified contract under Section 1035 of the Internal Revenue Code.

- ☐ Full Surrender
- ☐ Partial Surrender – $_____
- ☐ Cost Basis Requested: In accordance with the Tax Equity and Fiscal Responsibility Act of 1982, furnish a statement to the Assignee and to the former contract holder of the cost basis in the contract.

## ABSOLUTE ASSIGNMENT

☐ The owner of the above contract(s) assigns ☐ all or ☐ part ownership and rights under the above numbered contracts absolutely to the following assignee, Western Catholic Union.

All previous designations of beneficiary and payee, and all previous elections of payment options under the contract(s), as to the amounts shown above are irrevocably transferred. The sole beneficiary and payee of the partial or total amounts shown above shall be the above-named assignee. The assignment is subject to any prior collateral assignments affecting the contracts.

The assignee shall place the transferred amount into contract number _____ on behalf of the insured.

## CONTRACT

☐ Contract is attached.

☐ Contract is lost. I/We certify that the above numbered contract has been lost or destroyed, and to the best of my/our knowledge and believe it is not in anyone's possession.

## FEDERAL INCOME TAX WITHHOLDING

Even if you elect not to have federal income tax withheld, you are liable for payment of federal income tax on the taxable portion of your surrender. You also may be subject to tax penalties underestimated tax payment rules if your payments of estimated tax and withholding if any are not adequate.

☐ I do not want any federal income tax withheld for the surrender of the contract.

☐ I do want to have federal income tax withheld. $_____ or _____%.

## MINIMUM DISTRIBUTION – IRA CONTRACTS ONLY

If you are age 73 or older, please be sure to enter the following information:

☐ Please proceed with the transfer of the proceeds, I have already taken my minimum distribution for the current year.

☐ I have not yet taken my minimum distribution, but please proceed with the transfer, I will take it later this year.

☐ Please retain my minimum distribution until such time as it is required to be distributed.

## AUTHORIZATION

I am aware of any surrender/withdrawal penalties which may apply, and I authorize the transaction described above. This transfer request also authorizes Western Catholic Union to act on my request and to receive any information and proceeds because of this transfer.

I have completed a Western Catholic Union annuity or life application and other documentation required for this transfer.

Western Catholic Union will immediately endorse the proceeds check to the contract number, _____, I have applied for upon receipt of the funds.

I understand the amount of the proceeds may vary depending upon the exact date of the transfer. I respectfully request that this transfer be accomplished as quickly as possible and thank you in advance for your cooperation in this matter.

**I also authorize Western Catholic Union or its representative to inquire about the status of this transfer/exchange on my behalf any time prior to the transfer of these funds.** _____
Insured/Owner Initials

Please make the check payable to **Western Catholic Union**.

For the benefit of _____

Dated at _____ this _____ day of _____, 20_____

Signature of Owner: _____

Signature of Joint Owner: _____

* Signature of Spouse: _____

Signature of Witness: _____

**If required:**
Medallion Stamp Signature Guarantee: _____ **Affix Medallion Stamp Above**

*** If you reside in one of the following community property states, the spouse must also sign:**
Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin.

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

# REPLACEMENT OF ANNUITIES OR LIFE INSURANCE

## INFORMATION

Applicant: _____ Joint Applicant: _____

Producer: _____ Agent #: _____

## IMPORTANT NOTICE

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the insurance producer or company that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

List below the identification of policies which are involved in the replacement transaction.

Company: _____ Contract #: _____

Company: _____ Contract #: _____

Company: _____ Contract #: _____

Company: _____ Contract #: _____

**I certify that the responses herein are, to the best of my knowledge, accurate:**

Applicant's Signature: _____ Date: _____

Joint Applicant's Signature: _____ Date: _____

Producer's Signature: _____ Date: _____

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# ILLUSTRATION ACKNOWLEDGEMENT AND CERTIFICATION

## ACKNOWLEDGEMENT

Our company and some other states require that you receive a basic life insurance illustration at the time of application for this life insurance policy. The basic illustration explains the policy's features, benefits and values, including its guaranteed and non-guaranteed elements. However, when a basic illustration is not available for any of the reasons described below, an illustration acknowledgement and certification form is required to be presented in its place.

I acknowledge that this Illustration Acknowledgement and Certification is being used for one or more of the following reasons:

1. I have viewed an illustration on a computer screen but did not receive a printed copy.

   The illustration was based on the following personal and policy information:

   Gender: ☐ Male ☐ Female; Age _____.

   Underwriting/Rating _____; Policy Type _____;

   Initial Death Benefit _____; Dividend Option (if any) _____;

2. I have viewed an illustration that does not exactly correspond to the policy for which I have applied.

3. I have not viewed any illustration regarding the policy for which I have applied.

4. I have received a quotation or composite illustration in connection with policies marketed on a group basis.

I understand that the policy applied for has elements that are not guaranteed and I have been advised that if my application is approved, I will receive and be required to sign and return a printed basic illustration corresponding to the policy issued no later than at the time of policy delivery.

Applicant Signature: _____ Date: _____

## CERTIFICATION

I certify that no illustration for the policy as applied for was used for one or more of the reasons set forth above. I also certify that I have explained to the applicant that the life insurance policy applied for has elements that are not guaranteed. I also certify that I have not represented any non-guaranteed elements as guaranteed.

Authorized Representative Signature: _____ Date: _____