WESTERN CATHOLIC UNION
A Fraternal Benefit Society Since 1877
510 Maine Street, Quincy, Illinois 62301
(800) 223-4928 (217) 223-9721 – Fax (217) 223-9726
www.wculife.org

This **Whole Life** application kit is for the state of:

Colorado, Maryland, Missouri, Pennsylvania, Texas, West Virginia & Wisconsin

Contents:

Life Application – ICC21 LIFE APP FD 04/2021

- **MIB Pre-Notice Form –** ICC17 MIB PRE-NOTICE 08/2017
  - **Must be completed with all applications.**
- **MIB Authorization Form –** ICC17 MIB AUTHORIZATION 08/2017
  - **Must be completed with all applications.**
- **HIPPA Compliant Authorization to Release Health-Related Information Form –** ICC17 HIPAA AUTHORIZATION 08/2017
  - **Must be completed with all applications.**
- **Automatic Premium Payment Authorization (New Life Certificate) Form –** AUTO PREM PMT AUTH - LIFE 11/2025
  - **Must be used for monthly premium bank draft.**
- **Authorization to Transfer Funds Form –** TRANSFER 11/2021
- **Replacement of Annuities or Life Insurance Form –** REPLACEMENT 11/2021
- **Illustration Acknowledgement and Certification Form –** ILLUSTRATION ACK/CERT 11/2021
  - **Must be completed if no illustration is submitted at the time of the application.**
- **Life Receipt (for advance payments) –** COND REC 11/2021

Other forms that may be needed:

- **These can be found in the individual forms section at www.wculife.org**
  - **Additional Beneficiaries Form –** ADDITIONAL BENES 08/2025

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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.

WESTERN CATHOLIC UNION

A Fraternal Benefit Society Since 1877

510 Maine Street, Quincy, Illinois 62301

(800) 223-4928 – (217) 223-9721 – Fax (217) 223-9726

www.wculife.org

REPLACEMENT OF ANNUITIES OR LIFE INSURANCE

INFORMATION

Applicant: _____ Joint Applicant: _____

Producer: _____ Agent #: _____

IMPORTANT NOTICE

This document must be signed by the applicant(s) and the producer, if there is a producer, and a copy left with the applicant(s).

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its producer for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the producer in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because_____.
A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or producer that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your producer to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable? Could they change? You're older-are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid; you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy? Is this a tax-free exchange? (See your tax advisor.) Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code? Will the existing insurer be willing to modify the old policy? How does the quality and financial stability of the new company compare with your existing company?

NOTICE:
In the case of a replacement, you have the right to return the policy or contract within 30 days of its delivery and receive a full refund of all premiums or considerations paid, including any policy fee or charges.

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: _____

I **do not** want this notice read aloud to me. _____ (Applicant **must** initial only if they **do not** want the notice read aloud.)

RETURN TO WCU – PROVIDE COPY TO APPLICANT – KEEP COPY FOR YOUR RECORD

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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: _____

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LIFE RECEIPT

THIS RECEIPT DOES NOT PROVIDE ANY INSURANCE UNTIL ITS CONDITIONS ARE MET

Received from _____, in connection with an application for insurance on the life of _____, in the sum of $_____.

Please contact Western Catholic Union if you do not receive the certificate applied for or a refund of the amount paid within 60 days from the date of this Receipt. Please include the name of the agent and the date and amount paid.

All remittances must be payable to Western Catholic Union. Do not make payable to the Agent or leave the Payee blank.

FAIR CREDIT REPORTING ACT

Western Catholic Union may obtain an investigative consumer report, as you have authorized, whereby information is obtained through personal interviews with third parties, such as: family members; business associates; financial sources; friends; neighbors; or others with whom you are acquainted. This inquiry includes information as to your: character; general reputation; personal characteristics; and mode of living, whichever may be applicable. You have the right to make a written request, within a reasonable period of time for additional information concerning the nature and scope of such investigation, if made.

The insurance applied for will be effective on the later of: (1) the date of the application; or (2) the date of any initially required medical examination. Provided, the following conditions are met exactly: (1) the proposed insured is determined to be a standard risk for the amount and plan of insurance applied for in accordance with Western Catholic Union's underwriting rules then in effect; (2) the amount paid is not less than the full first premium for the amount and plan applied for; and (3) the payment is good and collectable. The maximum amount of life insurance, including accidental death, which may become effective under this Conditional Receipt, may not exceed $300,000; this amount includes any other pending application for the proposed insured.

MEDICAL INFORMATION BUREAU (MIB)

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.

ANNUITY RECEIPT

Received from _____ the sum of $_____ in cash, for an Annuity applied for this date to the WESTERN CATHOLIC UNION, Quincy, IL 62301.

This is a premium receipt, and it is expressly understood that the WESTERN CATHOLIC UNION, ASSUMES NO LIABILITY THEREUNDER until and unless the application is accepted by the society, under its rules, limits and standards, and any balance of first payment has been duly paid.

If the application for an Annuity applied for should not be acceptable to the Society, the Society will refund the payment in accordance herewith.

AUTHORIZED REPRESENTATIVE (Must complete for Life or Annuity)

Authorized Representative Signature: _____ Agent #: _____

Authorized Representative Printed Name: _____ Date: _____