Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
FORM: FRAUD-NJ

Cert. No. _____

Group No. _____

Association of the Sons of Poland

Home Office: 333 Hackensack Street, Carlstadt, NJ 07072
A Fraternal Benefit Society
(called the Sons of Poland)

ADULT APPLICATION

(Please Print)

Full Name _____ Sex _____

Street Address _____

City _____ State _____ Zip _____ Tel. ( ) _____

Date of Birth _____ Age at Nearest Birthday _____

Place of Birth _____ Amount Applied for $ _____

Social Security No. _____ Nationality _____

Occupation (state duties) _____

Father's Name _____ Mother's Maiden Name _____

Husband's or Wife's Name _____

Plan or Insurance
☐ Whole Life ☐ 20 Payment Life ☐ 3 PMT Life ☐ 20 YR Endowment
☐ Life Paid-Up at 65 ☐ Single Premium Life ☐ 5 PMT Life ☐ 15 YR Endowment
☐ _____ ☐ Benefactor Plan ☐ Adult Term

Mode of Payment
☐ Monthly ☐ Semi-Annual
☐ Quarterly ☐ Annual

Check Here If Automatic Premium Loan Option is Desired: ☐

NAME OF BENEFICIARY	RELATIONSHIP TO BENEFICIARY

Are you a member of the Sons of Poland? ☐ Yes ☐ No

Present Group No. _____

List insurance in force on your life (including Sons of Poland certificates):

COMPANY OR SOCIETY	YEAR ISSUED	LIFE AMOUNT	ADDITIONAL ACCIDENT AMOUNT

(1) Will the insurance applied for replace any insurance in force on your life?
☐ Yes ☐ No If Yes, complete requirements

(2) Height _____ft. _____in. Weight _____lbs.

(3) Weight change in past year:_____lbs. gained, or _____lbs. lost

(4) In the last 5 years have you:

a) Received medical advice or treatment for any injury, disease or disorder? ☐ Yes ☐ No

b) Undergone or been advised to undergo any surgery or diagnostic test? ☐ Yes ☐ No

c) Been a patient in any hospital or other medical facility? ☐ Yes ☐ No

d) Been arrested, counseled or treated for any condition related to the use of alcohol or drugs? ☐ Yes ☐ No

e) Been declined for, or required to pay more then the standard premium for, any insurance on your life? ☐ Yes ☐ No

(5) Have you ever had any form of cancer or heart disease? ☐ Yes ☐ No

(6) Do you now have any disease or any physical or mental impairment? ☐ Yes ☐ No

(7) Are you currently under prescription for any form of medication? ☐ Yes ☐ No

In this space, give the complete details for all "Yes" answers to questions (4) through (7):_____

_____

_____

_____

I desire to become a member of the Sons of Poland, I am familiar with its Constitution and By-laws and with the principles and objectives they contain. I understand and agree that all of my statements and answers, as recorded on this application, shall be part of the contract of insurance when and if one is issued. I declare that all such statements and answers are, to the best of my knowledge and belief, true and complete.

Signature of Applicant_____Date_____

Witness to Signature_____

STATEMENT BY INTRODUCING MEMBER OR GROUP OFFICER

Did you read every question to the Applicant and record all responses correctly? ☐ Yes ☐ No

Do you have any reason to doubt any of the information provided by the Applicant? ☐ Yes ☐ No

If so, please explain fully. _____

_____

Do you consider the Applicant a good insurance risk? ☐ Yes ☐ No

Will the insurance applied for replace any insurance in force on the life of the Applicant? ☐ Yes ☐ No

_____ _____

Date Signature of Introducing Member or Group Officer

REPORT OF MEDICAL EXAMINER

(1) Name of Applicant_____ Age_____

(2) Does Applicant appear to be the age stated? ☐ Yes ☐ No

(3) Is there any deformity, loss of member, or impairment of sight or hearing? ☐ Yes ☐ No

(4) Pulse rate_____ Is pulse regular? ☐ Yes ☐ No

(5) Blood pressure: Systolic_____ Diastolic_____

(6) Are heart sounds and rhythm normal? ☐ Yes ☐ No

(7) Is a murmur present? ☐ Yes ☐ No
Timing?_____ Transmission?_____
Effect of exercise?_____ Degree?_____

(8) Indication of hypertrophy? ☐ Yes ☐ No; Dilatation? ☐ Yes ☐ No

(9) Heart diagnosis_____

(Comment if exercise causes undue dyspnea)

(10) Urine: Specific Gravity_____ Albumin?_____ Sugar?_____

(11) Do you find any abnormality in:

A. Brain and nervous system?	☐ Yes ☐ No
B. Thyroid or lymph glands?	☐ Yes ☐ No
C. Chest, lungs and respiratory tract?	☐ Yes ☐ No
D. Digestive system or abdominal organs?	☐ Yes ☐ No
E. Genito–urinary system?	☐ Yes ☐ No
F Skin, bones, joints, spine?	☐ Yes ☐ No

(12) Is any factor not revealed above likely to affect longevity? ☐ Yes ☐ No

(13) How do you consider the insurance risk? ☐ Good ☐ Fair ☐ Doubtful

(14) Please furnish details regarding all adverse information in items (2) through (13) above:

_____

_____

_____

_____

I, the Medical Examiner, certify that I made the above statements, that they are based on my own examination, and that the Applicant signed in my presence.

_____
Signature of Applicant

_____ _____
Date Signature of Medical Examiner

Medical Examiner's Name (please print)_____

Address (include zip)_____

Examination Fee $_____

Cert. No._____ Group No._____

Name_____

Amount of Insurance $_____

Plan_____

Age at Entry_____

Premium $_____

payable _____

Accepted_____

General Secretary_____

To be used by Chief Medical Examiner:

Approved for $_____

Signature of Chief
Medical Examiner_____

Date_____

Form No. AA-85