YOUTH 3 PAY MEMBERSHIP INDIVIDUAL LIFE INSURANCE APPLICATION

1. Proposed Insured	Legal Name *(First, Middle Initial, Last)*		Phone	
	Address *(Street, City, State, Zip)*			
	Place of Birth *(State/Country)*		Social Security Number	
	Birth Date	Age	Gender ☐ Male ☐ Female	
	Is Proposed Insured a current member of GBU Financial Life?		☐ Yes	■ No
	Preferred District SOKOL 4000-			
2. Owner	Legal Name *(First, Middle Initial, Last)*			
	Address *(Street, City, State, Zip)*			
	Email		Phone	
	Social Security Number		Birth Date	
	Relationship to Proposed Insured			
3. Payor	Legal Name *(First, Middle Initial, Last)*			
	Address *(Street, City, State, Zip)*			
	Email		Phone	
	Social Security Number		Birth Date	
	Relationship to Insured			
4. Additional Contact Information	**Person to contact about policy if Proposed Insured, Payor or Owner cannot be located.**			
	Legal Name *(First, Middle Initial, Last)*			
	Address *(Street, City, State, Zip)*			
	Email		Phone	
	Relationship to Proposed Insured			
5. Insurance Applied For	**YOUTH 3 PAY LIFE MEMBERSHIP POLICY**	**Face Amount** (check one): ■ $3,000 ☐ $5,000 ☐ $10,000	**Annual Premium Amount: $**	
	Amount Paid with Application: *$*			
6. Dividend Option	☐ Cash	☐ Premium Reduction	■ Paid-Up Additions	☐ Accumulate at Interest
7. Beneficiary(ies)	**Primary Beneficiary(ies)**			
	Legal Name *(First, Middle Initial, Last)*			
	Address *(Street, City, State, Zip)*			
	Social Security Number			
	Relationship to Proposed Insured			Share %
	Legal Name *(First, Middle Initial, Last)*			
	Address *(Street, City, State, Zip)*			
	Social Security Number			
	Relationship to Proposed Insured			Share %

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YOUTH 3 PAY LIFE MEMBERSHIP INDIVIDUAL LIFE INSURANCE APPLICATION

7. Beneficiary(ies) *(continued)*

Contingent Beneficiary(ies)

Legal Name *(First, Middle Initial, Last)*	
Address *(Street, City, State, Zip)*	
Social Security Number	
Relationship to Proposed Insured	Share %
Legal Name *(First, Middle Initial, Last)*	
Address *(Street, City, State, Zip)*	
Social Security Number	
Relationship to Proposed Insured	Share %

Note: *If additional space is needed, list on a separate sheet of paper. Include the Policy Owner's signature and date.*

8. Active or Pending Insurance Policies

List active or pending life insurance policies of Proposed Insured. *(If none, so indicate.)*

Name of Company	Date of Issue or Pending Application	Life Amount	Accidental Death Benefit Amount	Replacement	
		$	$	☐ Yes	☐ No
		$	$	☐ Yes	☐ No

Will this contract replace an existing insurance policy?	☐ Yes	■ No
If yes, have you submitted the appropriate replacement forms?	☐ Yes	☐ No

9. Health

For Proposed Insured

Height	Weight	Primary Medical Provider's Phone

Primary Medical Care Provider
Name
Address *(Street, City, State, Zip)*

Date and reason of last visit

What treatment was given?
Or medication prescribed?

Was the Proposed Insured born prematurely or with abnormalities at birth diagnosed by a medical professional?	☐ Yes	☐ No
Has the Proposed Insured been treated or diagnosed by a medical professional for a respiratory disorder, heart disease or disorder, kidney or liver disease, diabetes, mental disease or disorder or cancer?	☐ Yes	☐ No

10. Additional Details

Please provide additional details on: Illness or Injury, Dates, Names and Addresses of Doctors/Hospitals and Degree of Recovery

11. Details, Remarks or Special Requests

Policy premiums paid monthly - see bank draft authorization

AGREEMENT – AUTHORIZATION – ACKNOWLEDGEMENT

This authorization complies with the HIPAA Privacy rule.

I understand I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. Written notice must be sent to GBU Financial Life, PO Box 645949, Pittsburgh, PA 15264-5257. I, the Parent/Guardian of the Proposed Insured (and any Payor or Owner signing below), by my signature set forth hereafter

AGREE to the following:

a) All statements and answers in this application are complete and true to the best of my knowledge and belief.
b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and policy is delivered while the health of any Proposed Insured continues, without any material change, to be as represented in this application.
c) No agent has authority to waive any answer; otherwise modify this application; or bind GBU Financial Life, hereinafter called "Company" in any way by making any promise or representation which is not set out in writing in this application.
d) $_____ has been deposited toward payment of the first premium on the policy. The terms of the Conditional Receipt received for that premium deposit are accepted.

I AUTHORIZE any physician; medical practitioner; hospital; clinic; other medical or medically related facility; to give the Company or its reinsurer(s) all information it holds that pertains to medical consultations; treatments; surgeries; and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes a pharmacy benefits manager; insurance support organization; pharmacy/government agency; insurance or reinsuring company; MIB, Inc. ("MIB"); consumer reporting agency; or any other organization; institution; or person. This authorization also includes information about drugs and alcoholism or any other non-health (non-medical) history information.

I authorize the Company or its reinsurers to release any information including my physical health information obtained to reinsuring companies; MIB; or other persons or organizations performing business or legal service in connection with my application or claim. I further authorize the Company and its reinsurers to release any information that may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree that a photographic copy will be valid as the original and that it will be valid for 24 months from the date shown below. This time limit is permitted by applicable law in the state where the policy is delivered or issued for delivery.

I know examiners, reinsurers, attorneys or other medical director may disclose such health information for purposes of underwriting, compliance, record clarification or explanation. The aforementioned parties may also disclose such information in response to litigation, summons or subpoenas. I understand that after this information is disclosed the recipient may re-disclose it resulting in loss of protection by federal regulations.

I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation.

I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB databases if such codes are reported by the Company or its reinsurers (or the Company or its reinsurers becomes obligated to report such codes to MIB) while this authorization is in force.

I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage.

ACKNOWLEDGE receipt of the following notices:

a) "Notice of Information Practices" required by Public Law 91-508 and other information practices, statutes, and
b) Notification regarding MIB, Inc.

AGREEMENT – AUTHORIZATION – ACKNOWLEDGEMENT *(CONTINUED)*

I (We) declare that the Proposed Insured desires to unite with GBU members for the following reasons. (a) Financial security and fraternal benefits. (b) Charitable community involvement. (c) Share the appreciation of our members' culture and heritage. (d) Meet any other requirements for membership established by GBU. By purchasing an insurance product from GBU Financial Life, the Proposed Insured gains automatic membership in the society including all of its rights and privileges.

GBU Financial Life is licensed to do business in this state. As a not-for-profit organization, fraternal benefit societies are not included in the State 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.

Fraud Warning. 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 the state law.

Dated at _____, _____, on _____, 20 _____.
City State

_____ _____
Printed Name of Parent or Guardian Signature of Parent or Guardian

_____ _____
Printed Name of Owner *(if other than Parent or Guardian)* Signature of Owner *(if other than Parent or Guardian)*

_____ _____
Printed Name of Payor *(if other than Owner)* Signature of Payor *(if other than Owner)*

Leah Grabiak / GBU Home Office

_____ _____
Printed Name of Licensed Agent Signature of Licensed Agent

7777100

_____
Licensed Agent Number

INVESTIGATIVE CONSUMER REPORTS

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates.

IMPORTANT NOTICE

The underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including your own statements, the results of your physical examination (if required), and any reports we obtain from doctors or medical facilities where you have been treated.

NOTIFICATION REGARDING MIB, INC. ("MIB"): Information regarding your insurability will be treated as confidential. GBU Financial Life or its reinsurers may, however, make a brief report thereon to the MIB. The MIB is a not-for-profit membership organization of insurance companies operating an information exchange on behalf of its members. The MIB may also release information in your file to another MIB-member company to whom application may be made for life or health insurance coverage; or, a benefit claim is submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact the MIB at [866-692-6901]. If you question the accuracy of 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. MIB's information office address: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

GBU Financial Life or its reinsurers may also release information in 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. Information for consumers about the MIB may be obtained at its website **www.mib.com**.

THIS NOTIFICATION MUST BE GIVEN TO THE PROPOSED INSURED BEFORE THE APPLICATION IS COMPLETED.

Health Insurance Portability and Accountability Act (HIPAA)
Authorization to Obtain and Disclose Information

Name of Proposed Insured *(Please print.)* _____ Date of Birth _____

I, the named Insured above or the Personal Representative of the above-named Insured, hereby authorize any health plan, physician, nurse or medical practitioner or practitioner group, health care professional, hospital, clinic, health care facility, laboratory, pharmacy, pharmacy benefit manager, or other health care provider that has provided treatment, services, or payment on my behalf within the past ten (10) years ("My Providers") to disclose to GBU Financial Life (the 'Recipient'):

- Any and all information relating to the Insured's health, excluding psychotherapy notes, and the Insured's insurance policies and claims. This information includes, but is not limited to, information relating to any medical consultations, treatments, or surgeries, hospital confinements for physical and mental conditions, use of drugs or alcohol, drug prescriptions, and communicable diseases including HIV and AIDS,
- Identifying information about the Insured, including the Insured's name, address, telephone number, gender, and date of birth.

This authorization to provide the information outlined above also extends to:

- any insurance or reinsurance company, including but not limited to any company which may have provided the Insured with life, accident, health, and/or disability coverage, or to which the Insured may have applied for insurance coverage, but coverage was not issued,
- any consumer reporting agency or insurance support organization,
- the Medical Information Bureau (MIB, Inc.)

I understand that the information obtained will be used by the Recipient to:

- underwrite my application for coverage, make eligibility risk rating, and policy issuance determinations,
- obtain reinsurance and administer coverage,
- determine the Insured's eligibility for benefits under and/or the contestability of an insurance policy, and
- detect fraud or abuse and for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs and activities.

By signing this authorization, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction, except as specified above.

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This authorization shall remain valid and in force for thirty (30) months following the date of my signature below. Copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to GBU Financial Life, Attention: Chief Underwriter, PO Box 645949, Pittsburgh, PA 15264-5257. I understand that my revocation is not effective to the extent that any of My Providers, as outlined above, have relied on this Authorization, to the extent that any action has been taken in reliance on this Authorization, or to the extent the GBU Financial Life has a legal right to contest a claim under an insurance policy or the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, GBU Financial Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received and reviewed a copy of this authorization.

Signature of Proposed Insured _____ Date _____

Describe the nature of the Personal Representative's authority over or relationship to the Proposed Insured

_____

_____

_____

GBU Life

Nonconforming Illustration/ Bank Draft Authorization Form

Applicant/Owner's Acknowledgement	I acknowledge that I did not receive a sales illustration containing full disclosure at the time when I completed the life insurance application. I understand that when the policy is issued, such an illustration will be provided to me at the time the policy is delivered to me.
	Applicant's Signature Date

Bank Draft Authorization Form

I hereby authorize GBU Financial Life (hereinafter called GBU) to initiate debit entries for premiums due on the insurance policies referred to in item number five (5) to my (our) account at the financial institution indicated.

Bank Information	Bank Name	
	Bank Address	
	Bank Branch, if any	
	Bank Phone	
Account Information	☐ Checking	
	Routing Number *(9-digits)*	
	Account Number	
	☐ Savings	
	Routing Number *(9-digits)*	
	Account Number	
	Withdraw funds on the ☐ **6th** or ☐ **20th** day of the month. *(Please choose one.)*	

It is agreed that:

1) Notice of debit amounts will not be mailed. Check-O-Matic premiums by GBU will appear on the bank statement.
2) This plan shall not be construed as a modification of any of the provisions of the certificates, as long as this plan is in effect.
3) The plan will remain in effect unless terminated by me or GBU upon thirty (30) days written notice. In addition, the GBU may terminate the plan if any debit is not paid upon presentation.
4) If this premium method is discontinued for any reason, premiums for such insurance shall thereafter be payable annually, semi-annually, quarterly, or monthly at GBU's rate in effect on the date of issue of such insurance.
5) This authorization shall apply to the following:

Reference/ Policy Number/ Comments	(a)	
	(b)	
	(c)	
	(d)	
Signature	Legal Name *(First, Middle Initial, Last)*	Phone
	Address *(Street, City, State, Zip)*	
	Signature Date	
Other Signature *(If joint account)*	Legal Name *(First, Middle Initial, Last)*	Phone
	Signature Date	

INCOMPLETE APPLICATIONS WILL BE RETURNED.

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GBU Life

Make a Difference: One Member at a Time

GBU believes strongly in the concept of making a difference in the lives of others by recognizing all new members who join the GBU family with a $25 donation to a nationally recognized charity. GBU encourages all new members to participate in this worthwhile program by asking you to select one of the charities listed. By doing this, GBU and you will be joining hands in making a difference for others.

☐ **American Cancer Society** (Health) ***www.cancer.org***
Mission Statement: To eliminate cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service.

☐ **American Liver Foundation** (Health) ***www.liverfoundation.org***
Mission Statement: To facilitate, advocate and promote education, support and research for the prevention, treatment and cure of liver disease.

☐ **American Red Cross** (Human Services/Disaster Relief) ***www.redcross.org***
Mission Statement: Prevents and alleviates human suffering in the face of emergencies by mobilizing the power of volunteers and the generosity of donors.

☐ **Feeding America** (Human Services/Disaster Relief) ***www.feedingamerica.org***
Mission Statement: To feed America's hungry through a nationwide network of member food banks and engage our country in the fight to end hunger.

☐ **Guiding Eyes for the Blind** (Human Services) ***www.guidingeyes.org***
Mission Statement: Guiding Eyes for the Blind is dedicated to enriching the lives of blind and visually impaired men and women by providing them with the freedom to travel safely, thereby assuring greater independence, dignity and new horizons of opportunity.

☐ **Marine Toys for Tots Foundation** (Children/Family Services) ***www.toysfortots.org***
Mission Statement: To collect new, unwrapped toys during October, November and December each year and distribute those toys as Christmas gifts to less fortunate children in the community in which the campaign is conducted.

☐ **National Center for Learning Disabilities** (Education) ***www.ncld.org***
Mission Statement: To improve the lives of the one in five children and adults nationwide with learning and attention issues—by empowering parents and young adults, transforming schools and advocating for equal rights and opportunities.

☐ **National Parks Conservation Association** (Environment) ***www.npca.org***
Mission Statement: To protect and enhance America's National Parks for present and future generations.

☐ **Operation Troop Appreciation** (Military/Veterans) ***www.operationtroopappreciation.org***
Mission Statement: To build and sustain the morale and well-being of the military community, past and present, with the assurance that the American public supports and appreciates their selfless service and daily sacrifices.

☐ **Humane Society of the United States** (Animal Rights and Care) ***www.humanesociety.org***
Mission Statement: Together with millions of supporters, we take on puppy mills, factory farms, the fur trade, trophy hunting, animal cosmetics testing and other cruel industries. We rescue and care for thousands of animals every year through our Animal Rescue Team's work and other hands-on animal care services. We fight all forms of animal cruelty to achieve the vision behind our name: A humane society.

*Please visit GBU at **www.gbu.org** to learn more about GBU, member benefits and our desire to help others.*

Member's Signature _____

Email *(please print clearly)*: _____

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