☐ IPR Option

HERMANN SONS LIFE

Application for Life Insurance & Membership

DATE OF SIGNED/COMPLETED APPLICATION *(must match date on Signature Page 6)*

PROPOSED INSURED INFORMATION

PLEASE PRINT IN BLUE OR BLACK INK ONLY

FULL NAME — FIRST | MIDDLE | LAST | SUFFIX

DATE OF BIRTH (MM/DD/YYYY)

MAILING ADDRESS | CITY | STATE | ZIP CODE | SOCIAL SECURITY NO. (XXX-XX-XXXX)

EMAIL ADDRESS

HOME PHONE NO. (XXX-XXX-XXXX) | CELL PHONE NO. (XXX-XXX-XXXX) | WORK PHONE NO. (XXX-XXX-XXXX)

AGE | SEX | BIRTHPLACE (City and State)

MARITAL STATUS ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Is proposed insured a citizen of the United States? ☐ Yes ☐ No

If no, does proposed insured plan to become a citizen? ☐ Yes ☐ No

OCCUPATION/JOB DESCRIPTION | FIRM NAME

OWNERSHIP INFORMATION ☐ Check if same as Proposed Insured.

OWNER'S FULL NAME — FIRST | MIDDLE | LAST | SUFFIX

DATE OF BIRTH (MM/DD/YYYY)

MAILING ADDRESS | CITY | STATE | ZIP CODE | SOCIAL SECURITY NO. or EIN

EMAIL ADDRESS | PHONE (XXX-XXX-XXXX)

Please Choose **One** Designation: ☐ *If Living Otherwise* * OR * ☐ *And*

If you fail to choose a designation or if your choice is unclear *If Living Otherwise* is assumed.

OWNER'S FULL NAME — FIRST | MIDDLE | LAST | SUFFIX

DATE OF BIRTH (MM/DD/YYYY)

MAILING ADDRESS | CITY | STATE | ZIP CODE | SOCIAL SECURITY NO. or EIN

EMAIL ADDRESS | PHONE (XXX-XXX-XXXX)

PROPOSED INSURED MEDICAL INFORMATION

	YES	NO
1. (a) Exact Height ____ ft. ____ in. (b) Weight ____ lbs.		
2. Have you gained or lost weight within the last two years? ☐ Gained ☐ Lost (If "YES", give amount and reason.)	☐	☐
3. Do you currently or have you ever used tobacco, nicotine or vape products? If "YES," give type, amount and dates used.	☐	☐
4. Have you ever had a life insurance application declined, postponed, rated, modified, or withdrawn? If "YES", give name of company(ies), date and reason.	☐	☐
5. Have you ever had your driver's license suspended or revoked; or ever been convicted of DWI or DUI; or in the past 3 years been convicted of more than one moving violation? If "YES," please provide driver's license number and details.	☐	☐
6. Except as prescribed by a physician, have you ever used, or been convicted for the sale or possession of cocaine or any other narcotic or illegal drug? **If "YES," complete the Drug Usage Questionnaire.**	☐	☐
7. Have you ever been treated for, received counseling, been advised to seek counseling, or joined a support organization because of ALCOHOL or DRUG usage? **If "YES," complete the Alcohol Usage Questionnaire.**	☐	☐
8. Have your PARENTS, BROTHERS or SISTERS ever had diabetes, cancer, high blood pressure, heart disease or a congenital disorder? If "YES", give relationship, condition, age at diagnosis and current age or age at time of death.	☐	☐
9. Have you ever been treated or evaluated at a hospital, clinic or other facility, or been advised to have any test or surgery not yet completed? (If "YES", explain.)	☐	☐

	YES	NO
10. Have you had or been told you had AIDS,AIDS Related Complex or AIDS related symptoms? Or have you ever tested positive for antibodies to the AIDS (Human T-cell Lymphotropic Type III; HTLV-I(I)?	☐	☐
11. Have you received treatment by a member of the medical profession in connection with any of the categories mentioned in #10?	☐	☐
12. To the best of your knowledge and belief, in the past 10 years, have you been medically treated for, or been diagnosed as having:		
a) Any disorder of the heart, circulatory, blood or immune system? (Examples include chest pain, heart murmur, heart attack, abnormal heart beat, high blood pressure, varicose veins, shortness of breath, disorder of blood vessels, anemia, etc.)	☐	☐
b) Cancer, tumor, cyst, growth or enlargement of the lymph gland?	☐	☐
c) Any disorder of the Respiratory System? (Examples include Allergies, Asthma, Bronchitis, Emphysema, Tuberculosis, Reactive Airway Disease, or other lung disorders.) **If "YES," complete the Respiratory Questionnaire.**	☐	☐
d) Any disorder of the digestive system, such as disease of the stomach, intestines, rectum, liver, gallbladder, esophagus, diarrhea of more than one week's duration, ulcer, hemorrhoids, polyps or hernia, etc.?	☐	☐
e) Any disorder of the urinary system? (Examples include references to the urinary organs or functions such as albumin, blood, sugar or pus in the urine; diseases of the kidney, bladder, etc.?)	☐	☐
f) Diabetes, abnormal blood sugar, thyroid, adrenal, parathyroid, pituitary or other glandular disorders. **If "YES," to diabetes or abnormal blood sugar, complete the Diabetes Questionnaire.**	☐	☐
g) Depression, anxiety, bipolar disorder, obsessive compulsive disorder, neurosis, psychosis, schizophrenia, attention deficit disorder (ADD/ADHD), affective disorders, eating disorder, hallucinations or any other mental behavioral, psychological, or psychiatric disorders? **If "YES," to ADD/ADHD complete the Attention Deficit/ Hyperactivity Disorder Questionnaire.**	☐	☐
h) Any disorder of the nervous system, such as epilepsy, convulsions, loss of consciousness, dizziness, paralysis, headaches, nervousness, mental disorder, or received psychiatric treatment or attempted suicide, etc.?	☐	☐
i) Any disorder of the muscles, skin or bone? (Examples include gout, arthritis, collagen disease (connective tissue disease), disorders of the back, joints, extremities, muscles, etc.; or received chiropractic or therapist consultation.)	☐	☐
j) Any disorder or the male or female reproductive organs? (Examples depending on gender include menstrual disorder, complications of pregnancy, Caesarean section, or prostate disorder, etc.)	☐	☐
k) Any disorder of eyes, ears, nose or throat? (Except for cataracts, not necessary to include vision corrected with glasses or contact lenses.)	☐	☐

PROPOSED INSURED LIFESTYLE & HAZARDOUS ACTIVITY INFORMATION

14. Have you been a pilot or student pilot, crew member or had any duties on board an aircraft in flight during the past 3 years? ***If, "YES", complete the Aviation Questionnaire.*** ☐ Yes ☐ No

15. Have you engaged in any hazardous sports, amusement or avocation activities during the past 3 years? Examples include Scuba Diving, Parachuting, Vehicle or Boat Racing, Ballooning or Hang Gliding. ***If, "YES", complete the Sport, Amusement or Avocation Questionnaire.*** ☐ Yes ☐ No

16. Do you plan to travel or reside outside of the United States? If "Yes," give reason, destination and length of stay: ☐ Yes ☐ No

PLEASE INCLUDE ALL TESTS, DIAGNOSIS, DURATION, MEDICATION AND TREATMENTS						
TEST PERFORMED	DIAGNOSIS	DATE BEGAN MO/YR	DATE ENDED MO/YR	MEDICATIONS	TREATMENTS	FULL NAME, ADDRESS & PHONE NO. OF PHYSICIANS & HOSPITALS

PROPOSED INSURED PRIMARY CARE PHYSICIAN

NAME FIRST LAST

ADDRESS

CITY STATE ZIP

PHONE NO. XXX-XXX-XXXX

OTHER INSURANCE IN FORCE ON PROPOSED INSURED

Does the proposed insured have existing insurance with Hermann Sons Life? ☐ Yes ☐ No

Was proposed insured previously a member under a different last name? ☐ Yes ☐ No

If "Yes", explain

Life insurance in force or pending (Complete all columns and amount of each benefit.) Check if none ☐

COMPANY	LIFE AMOUNT	ACCIDENTAL DEATH AMT.	COMPANY	LIFE AMOUNT	ACCIDENTAL DEATH AMT.

Amount of insurance on the spouse:

APPLICATION FOR MEMBERSHIP

The proposed insured does hereby apply to Local lodge name and number

Recommended by Certificate No.

NEWSPAPER ☐ YES ☐ NO

☐ BY EMAIL TO

COVERAGE APPLIED FOR

PLAN APPLIED FOR	AMOUNT OF INSURANCE	2ND PLAN APPLIED FOR	AMOUNT OF INSURANCE

PREMIUM $ _____ PREMIUM $ _____

SUPPLEMENTAL CONTRACT $ _____ SUPPLEMENTAL CONTRACT $ _____

- ☐ INSURANCE PROTECTION RIDER
- ☐ ACCIDENTAL DEATH
- ☐ PREMIUM WAIVER

LODGE DUES $ _____

TOTAL $ _____ TOTAL $ _____

GRAND TOTAL $ _____

MODE OF PAYMENT

- ☐ SINGLE
- ☐ ANNUAL
- ☐ SEMI-ANNUAL
- ☐ QUARTERLY
- ☐ MONTHLY
- ☐ BANK DRAFT (See below)
- ☐ EXISTING BANK DRAFT

MONEY WITH APPLICATION

- ☐ PERSONAL CHECK
- ☐ AGENT'S CHECK
- ☐ CASH
- ☐ MO/CASHIER'S CHECK
- ☐ BANK DRAFT
- ☐ NO MONEY WITH APPLICATION

BILLING INFORMATION

PAYOR'S FULL NAME | DATE OF BIRTH

FIRST	*MIDDLE*	*LAST*	*SUFFIX*	*MM/DD/YYYY*

RELATIONSHIP TO PROPOSED INSURED | OCCUPATION | PHONE

		XXX-XXX-XXXX

MAILING ADDRESS | CITY | STATE | ZIP CODE

EMAIL ADDRESS

PICTURE ID REQUIRED # _____ TYPE _____

BANK DRAFT INFORMATION

Name of bank or credit union to be drafted _____

Name(s) of authorized users on account _____

_____

Type of account: ☐ Checking ☐ Savings

Routing No.: _____

Account No.: _____

Draft frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Draft Date: ☐ 1st of month drafting ☐ 15th of month drafting

I hereby give the above mentioned bank or credit union authorization to honor electronic drafts drawn from my account by Hermann Sons Life for insurance or annuity payments on the above listed accounts. I understand that if my bank rejects a draft request for any reason, it is still my responsibility to pay the defaulted amount immediately and I will contact Hermann Sons Life for payment options. I further understand that Hermann Sons Life is not responsible for bank overdraft charges or other related draft fees.

Signature of Account Holder _____

BENEFICIARY DESIGNATION

FULL NAME | DATE OF BIRTH

FIRST | MIDDLE | LAST | SUFFIX | MM/DD/YYYY

RELATIONSHIP | SOCIAL SECURITY NO.

XXX-XX-XXXX

Please Choose **One** Designation: ☐ *If Living Otherwise* * OR * ☐ *And*

If you fail to choose a designation or if your choice is unclear *If Living Otherwise* is assumed.

FULL NAME | DATE OF BIRTH

FIRST | MIDDLE | LAST | SUFFIX | MM/DD/YYYY

RELATIONSHIP | SOCIAL SECURITY NO.

XXX-XX-XXXX

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If you fail to choose a designation or if your choice is unclear *If Living Otherwise* is assumed.

FULL NAME | DATE OF BIRTH

FIRST | MIDDLE | LAST | SUFFIX | MM/DD/YYYY

RELATIONSHIP | SOCIAL SECURITY NO.

XXX-XX-XXXX

Please Choose **One** Designation: ☐ *If Living Otherwise* * OR * ☐ *And*

If you fail to choose a designation or if your choice is unclear *If Living Otherwise* is assumed.

FULL NAME | DATE OF BIRTH

FIRST | MIDDLE | LAST | SUFFIX | MM/DD/YYYY

RELATIONSHIP | SOCIAL SECURITY NO.

XXX-XX-XXXX

FIELD UNDERWRITER/AGENT NOTES

HOME OFFICE ENDORSEMENTS ONLY (Do not write in this space.)

SIGNATURES

BEFORE SIGNING, PLEASE READ THE FOLLOWING:

I, the proposed insured, if accepted, agree to become a faithful member of Hermann Sons Life and to abide by all Local Lodge Bylaws and the Charter, as the same are now in force and effect and as the same may hereafter be amended, passed or enacted. I am aware that I am not insured until I have been medically approved.

I hereby certify that the statements and answers in the Application and any supplements or amendments thereto, are made by me and are complete and true, that they are correctly and fully recorded, and that no material circumstances or information has been withheld or omitted concerning my past and present state of health and habits of life.

I agree (1) that acceptance of such certificate shall constitute ratification of the contracts as written, together with any corrections, additions or changes made by Hermann Sons Life and entered in the space provided for "Home Office Endorsements Only"; (2) that such certificate shall not be issued and become effective until after I have paid the first premium; (3) that no person other than the President or the Vice President of Operations can act for Hermann Sons Life to make, modify, or discharge the contract or waive any of its requirements; and (4) that this application and any supplements or amendments thereto constitute a part of the contract or the parties hereto.

I am aware that I am not qualified to enjoy any benefits of the local lodge of Hermann Sons Life until I am accepted into the local lodge to which application is made.

I acknowledge receipt of the **NOTICES TO PROPOSED INSURED**, Parts One and Two.

As a member of Hermann Sons Life, I understand that membership dues are required. _____ (Member initials)

AUTHORIZATION TO RELEASE INFORMATION

The undersigned proposed insured hereby authorizes 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 proposed insured or proposed insured's health, to give to HERMANN SONS LIFE, or its reinsurer(s), any such information. The undersigned proposed insured also authorizes HERMANN SONS LIFE, or its reinsurers, to make a brief report of the proposed insured's personal health information to MIB, Inc.ww

Signed at _____, Texas, on this date _____

Proposed Insured **X** _____
(Only if 18 years of age or older)

Parent/Guardian **X** _____
(If proposed insured under 18 years)

Owner **X** _____
(If other than proposed insured or parent/guardian, and wishes to maintain ownership of certificate)

Witnessed by _____ Agent Signature

AGENT'S NAME (Please print) _____ AGENT'S NO. _____

The undersigned proposed insured hereby acknowledges possession of the Conditional Receipt attached to this application.

_____ **X** _____
DATE SIGNATURE OF PROPOSED INSURED (Payor if proposed insured is under 18)

CONDITIONAL RECEIPT

HERMANN SONS LIFE

Home Office
515 S. St. Mary's St • P.O. Box 1941 • San Antonio, TX 78297

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

If, within the last 12 months, any person proposed for coverage has been treated for heart trouble, stroke, or cancer, no payment may be accepted with the application.

Received from _____ the sum of $_____ an amount equal to the first full premium specified in the application for insurance in Hermann Sons Life.

If the first full premium according to the mode of premium payment has been paid, and all underwriting requirements (medical examinations, tests, x-rays, EKGs, etc.) have been completed and received at the Home Office within 90 days from the date of application and the requirements of the bylaws of Hermann Sons Life have been met, and the proposed insured is insurable according to the rules of Hermann Sons Life for the plan of insurance and the amount applied for without modification either as to plan, amount, riders, supplemental agreements and/or the rate of premium paid, THEN the insurance, so provided by the terms and conditions of the contract applied for and in use by Hermann Sons Life on the Effective Date, shall become effective as of the Effective Date. "Effective Date" as used herein, is the later of: (a) the date of completion of the Application or (b) the date of completion of all medical examinations.

THE AMOUNT OF INSURANCE WHICH MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY SHALL NOT EXCEED $100,000.

If one or more of the conditions above have not been completely fulfilled, then Hermann Sons Life shall have no liability in connection with this receipt except to return the amount paid upon surrender of this receipt. This receipt shall be void if given a check or draft which is not honored upon presentation for payment.

Dated at _____

Signature of Agent _____ Date _____

NOTICES TO PROPOSED INSURED

PART ONE

Federal law requires that notice of investigation be given to persons applying for insurance.

In making this application for insurance to HERMANN SONS LIFE, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and score of any investigation (See Part Two).

PART TWO

Information regarding your insurability will be treated as confidential. HERMANN SONS LIFE or its reinsurers may, however, make a brief report of your personal health information thereon to **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, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is **[50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**].

HERMANN SONS 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 MIB, Inc. may be obtained on its website at www.mib.com.**