NEW JERSEY LIFE APPLICATION CHECKLIST

REQUIRED FORMS—WHOLE & TERM ADULT, WHOLE JUVENILE

- ☐ Application for Life Insurance - Form-ICC16-LAPP2016
- ☐ Application for Juvenile Term Life - Form AC-10-86
- ☐ Authorization for Release of Health-Related Information—Exam One (rev 10.2017)
- ☐ NJ Fraud—Form NJFW-01/99
- ☐ SPWL Illustration Compliance Certification Form – (**only if no illustration for SPWL**)

IF DOING A REPLACEMENT

- ☐ Notice Regarding Replacement of Life Insurance and Annuities – Form R-1 (2017)
- ☐ If doing a 1035 exchange – need to complete – (Form 1035 – Absolute Assignment)

OPTIONAL FORMS

- ☐ If Diabetic – Diabetic Questionnaire
- ☐ If High BP - Blood Pressure Questionnaire
- ☐ EFT – (Electronic Funds Transfer Form, if they want premium automatically deducted)
- ☐ MIB Authorization to Obtain, Release, and Disclose Medical Information / MIB Pre-Notice – (**if over retention & requires reinsurance**, section C in Rate Book)-HIPAA-2016-01-01

WILLIAM PENN ASSOCIATION

FRATERNAL LIFE INSURANCE AND ANNUITIES
709 Brighton Road, Pittsburgh, PA 15233-1821

BRANCH NUMBER

HO Use Only / Issue Date:

CERTIFICATE NUMBER

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

1a. Proposed Insured
Name: First _____ M.I. _____ Last _____ ☐Male ☐Female
Date of Birth: _____ Place of Birth: _____ Height: _____ Weight: _____
Address: _____
Employer: _____ Occupation: _____ How long at occupation: _____
Soc. Sec. #: _____ Telephone #: _____ Marital Status: _____

1b. Adult Applicant or Owner Information (If other than the Proposed Insured)
Name: First _____ M.I. _____ Last _____ Date of Birth: _____
Address: _____
Soc. Sec. #: _____ Relationship to Proposed Insured: _____

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2. a. Plan: _____ Face Amount: _____
b. Rider Benefits: Plan _____ Face Amount/Units: _____
Supplemental Benefits: ☐ADB ☐DADB ☐WP ☐PAYOR WP (available on minor applicants only)
Other: _____
c. Premiums to be paid: ☐Annually ☐Semi-Annually ☐Quarterly ☐Monthly ☐Single Premium
d. Amount paid with application: $ _____
e. Automatic Premium Loan, if applicable: ☐No ☐Yes

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3. BENEFICIARY (If listing more than one primary and/or contingent, complete all requested information on additional sheet and attach.)
Primary: Name: First _____ M.I. _____ Last _____ Date of Birth: _____
Soc. Sec. #: _____ Relationship to Proposed Insured: _____ Share: _____ %
Address: _____
Contingent: Name: First _____ M.I. _____ Last _____ Date of Birth: _____
Soc. Sec. #: _____ Relationship to Proposed Insured: _____ Share: _____ %
Address: _____

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4. In the past five years, has the Proposed Insured:
a. used tobacco in any form, including E-Cigarettes: ☐No ☐Yes If no longer used, show date stopped: _____
b. used marijuana, heroin, cocaine, or other opiate or barbiturate not prescribed by a physician: ☐No ☐Yes
c. engaged in any form of racing, scuba diving, parachuting, hang gliding, rock climbing, or any similar hazardous sport or avocation; or intend to do so in the next two years: ☐No ☐Yes
d. flown as a pilot or crew member of any type of aircraft; or intend to do so in the next two years: ☐No ☐Yes
e. been convicted of a moving traffic violation or been at fault in a motor vehicle accident: ☐No ☐Yes
If yes, list Proposed Insured's driver's license number: _____ State of Issue: _____

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5. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession, or been confined in a medical care facility, or had such confinement recommended by a member of the medical profession, for:
a. abnormal blood pressure, heart attack, coronary artery disease, bypass surgery, stents, stroke, Transient Ischemic Attack (TIA), or any other disorder or disease of the heart, blood vessels, or of the circulatory or cerebrovascular system? ☐No ☐Yes
b. cancer, tumor, lymphoma, polyps, melanoma or any other malignancy, growth or lump? ☐No ☐Yes
c. diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder? ☐No ☐Yes
d. any ear, nose, throat, lung disorder, or any respiratory disorder, to include COPD or sleep apnea? ☐No ☐Yes
e. any disorder of the stomach, intestines, rectum, liver, or pancreas, kidney or bladder? ☐No ☐Yes
f. lupus, arthritis, autoimmune disease, or any injury to or disease of the bones, muscles, joints, eyes, or skin? ☐No ☐Yes
g. epilepsy, seizures, tremor, paralysis, Parkinson's, Alzheimer's, or any other disease or disorder of the nervous system? ☐No ☐Yes
h. anxiety, depression, alcohol or drug abuse, or any emotional, behavioral, mental or nervous disorder? ☐No ☐Yes
i. AIDS (Acquired Immune Deficiency Syndrome), positive HIV test, or any other immunological disorder? ☐No ☐Yes
j. any other impairment, disease or disorder, during the past 5 years, not listed above? ☐No ☐Yes
For any "Yes" answer above, give details (Attach additional sheet if more space needed): _____

6. Other than as stated, has the Proposed Insured during the past 5 years:
   a. consulted, received treatment, or been prescribed medication by a member of the medical profession? ☐No ☐Yes
   b. had any abnormal diagnostic/screening tests? ☐No ☐Yes
   c. scheduled a diagnostic/screening test or surgical or non-surgical procedure that has not yet been completed? ☐No ☐Yes
   d. been convicted of or pled guilty to a felony or misdemeanor? ☐No ☐Yes If yes, give details: _____

7a. Full name of family physician, if none so state: _____
Address: _____ Telephone #: _____
Date of most recent visit: _____ Reason for most recent visit: _____ Results: _____
Date of most recent physical exam: _____ Results: _____

b. Does the Proposed Insured have a family history of cancer, heart disease, high blood pressure, stroke, or diabetes? ☐No ☐Yes
If Yes, list relationship, disorder, age at onset, and if deceased, age at death: _____

8a. ***This section to be completed ONLY if applying for Spouse Rider, Child Rider, or Payor Waiver Benefits under Question 2b.***

First Name	Last Name	Relationship to Proposed Insured	Date of Birth	Social Security #	Sex	Height	Weight	Insurance in Force

b. Has any person listed above ever had any of the conditions listed in Questions 5 & 6? ☐No ☐Yes If Yes, list name, condition, date(s), and name and address of attending physician: _____

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9. Dividend Election: ☐Cash ☐Reduce Premiums ☐Paid-Up Additional Insurance ☐Accumulate with Interest

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10. Is the Proposed Insured a member of William Penn Association? ☐No ☐Yes If No, apply for membership

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11a. Does the Proposed Insured have existing insurance or annuity policies? ☐No ☐Yes
If Yes, Name of Insurer(s): _____ Total Amount in Force: $ _____

b. Will the insurance being applied for here replace or change any existing insurance or annuity? ☐No ☐Yes
If Yes, Name of Insurer(s): _____ Policy Number(s): _____

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12. Special Requests: _____

Having read, or had read to me (us), the above statements and answers, I (we) represent, to the best of my (our) knowledge and belief, the information provided herein is correct and true. I (We) agree this application, and any continuation or supplement, shall be the basis for and a part of any contract issued. I (We) understand no agent or person other than an officer of William Penn Association has authority: (1) to make or modify contracts; or (2) to waive any of the rights or requirements of William Penn Association.

Except as may be provided in a Conditional Receipt bearing the same date as this application, I (we) understand no insurance will take effect until: (1) a contract is issued and delivered to its owner; (2) the full first premium for the contract is paid; and (3) the health and other conditions affecting the insurability of each person for whom insurance is requested is as described in this application.

Fraud Notice/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 law.

I understand and acknowledge that I (we) have read the Fraud Notice/Warning printed above or that it has been read to me (us).

Dated and signed in the City and State of: _____ this _____ day of _____, 20____.

SIGNATURES

Proposed Insured (Age 16 or older): _____

Adult Applicant or Owner other than Proposed Insured: _____

If applicable under Question 8a, Spouse and/or Dependent Child Age 16: _____

Agent (Signature and State ID #, where required): _____

Print Name of Agent: _____ WPA Agent Number: _____

WILLIAM PENN ASSOCIATION 709 Brighton Road, Pittsburgh, PA 15233
AUTHORIZATION

Medical Authorization: I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc. (formerly known as the Medical Information Bureau), pharmacy benefit manager, pharmacy, insurance laboratory, a consumer reporting agency, my employer, or any other person or organization that has any record or information about me or my minor children to give William Penn Association, its reinsurers or its authorized representatives information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs, alcoholism, or other information the Company requires to determine insurability or eligibility of benefits.

I also authorize William Penn Association or its reinsurers to make a brief report of my personal health information to MIB, Inc. I further authorize the sources listed above, except for MIB, Inc., to give such information to a consumer reporting agency acting on behalf of William Penn Association. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent William Penn Association has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to William Penn Association at its administrative office address.

I agree that a copy of this authorization is as valid as the original, and I can obtain a copy on request. This authorization is valid for 24 months from the date signed, or the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.

_____ _____
Date Signature of Proposed Insured or Adult Applicant

_____ _____
Signature of Witness Signature of Spouse (if applying for insurance under this application)

WILLIAM PENN ASSOCIATION 709 Brighton Road, Pittsburgh, PA 15233
CONDITIONAL RECEIPT Do not use unless full payment is made with application.

Unless and until each and every condition specified in paragraph 1 on the reverse side is met exactly, no insurance will become effective until the contract is issued, delivered to and accepted by its Owner.

Received from:_____ the sum of: $_____

Paid with an application to William Penn Association on the life of _____, Proposed Insured. This Conditional Receipt is not valid unless: (1) it bears the same date as the date of the application; (2) the amount shown in this receipt is the same as the amount shown in the application; (3) any check, draft or money order tendered as payment is good and collectible; and (4) it is signed by the agent or representative who received the payment.

Payment Received by:_____ Date:_____
Signature of Agent or Representative

NOTE: Please notify William Penn Association if, within 30 days following the date of this receipt, you have not received: (1) the contract applied for; or (2) refund of your payment. Please be certain to include: (1) the amount paid; (2) the date of the payment; and (3) the name of the agent or representative to whom payment was made. All remittances must be made payable to: WILLIAM PENN ASSOCIATION. DO NOT MAKE PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. **ALL REFUNDS ARE MADE PAYABLE TO THE INSURED/OWNER, NOT THE PAYER OR AGENT.**

WILLIAM PENN ASSOCIATION 709 Brighton Road, Pittsburgh, PA 15233
FAIR CREDIT REPORTING ACT

William Penn Association 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.

AGENT'S REPORT

1. Will Paramedical exam be made? ☐No ☐Yes If Yes, give date, if known:_____
2. How long and how well have you known Proposed Insured? _____
3. What is Proposed Insured's approximate annual income? $_____
4. Is Proposed Insured married? ☐No ☐Yes If Yes, Spouse's Name: _____
   Amount of life insurance Spouse carries: $_____
5. Did you see Proposed Insured and all family members proposed for coverage at time of application? ☐No ☐Yes
6. Has the Proposed Insured or any covered persons applied elsewhere for any insurance in the past 6 months or have another application currently pending or being submitted to any other life insurance company? ☐No ☐Yes
7. Will the insurance now applied for replace or change any existing insurance? ☐No ☐Yes
   If Yes, have you submitted all appropriate replacement forms? ☐No ☐Yes
8. **WHAT PLAN OF INSURANCE IS BEING APPLIED FOR?** _____

	Amount or Units	Annual Premium		Amount or Units	Annual Premium
Base			Term Rider		
ADB			Spouse Rider		
DADB			Child Rider		
WP			Other		
PAYOR					

TOTAL ANNUAL PREMIUM _____

1. This Conditional Receipt does not create temporary or interim insurance. This insurance applied for will become effective only if the following conditions are met exactly: (a) the amount paid with the application is sufficient to pay at least one full premium, at the premium mode shown in the application, for the amount of insurance and plan, including any riders, applied for; and (b) all required parts of the application and any required tests and medical examination, for each Proposed Insured and any Payor, as required by William Penn Association's published underwriting rules at the age and for the amount of insurance applied for, are completed within 30 days of the date of this Conditional Receipt; and (c) each Proposed Insured and any Payor is insurable as a risk other than substandard for the insurance applied for as of the latest of the dates of the requirements described in part (b).

2. When the required conditions are met exactly, the insurance, under the terms of the contract and any rider, will become effective on the latter of: (a) the last date of all required parts of the application; or (b) the last date of any required tests and medical examination.

3. The insurance applied for shall NOT BE EFFECTIVE, and there shall be no liability on the part of William Penn Association other than to return the payment, should one or more of the conditions specified in paragraph 1, above, not be met exactly.

4. MAXIMUM AMOUNT LIMITATION: The maximum amount of insurance for which William Penn Association shall be liable under this Conditional Receipt shall be the lesser of: (a) the amount of insurance applied for; or (b) for any Proposed Insured whose age, nearest birthday, on the date of the application is: (1) 64 or younger, $100,000; or (2) 65 or older, $50,000. Such maximum amount shall include for each Proposed Insured: (a) the amount of insurance requested by the application; and (b) any other insurance currently applied for and pending with William Penn Association under another application or applications.

WILLIAM PENN ASSOCIATION
PRE-NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (MIB)

William Penn Association, or our reinsurers, may make a brief report to the MIB, Inc. MIB, Inc. is a not-for-profit membership organization of insurance companies that 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 of benefits is submitted to such a company, MIB, upon request, will supply the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek 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. The telephone number is 866-692-6901. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

WILLIAM PENN ASSOCIATION

A Fraternal Benefit Society

709 Brighton Road, Pittsburgh, PA 15233-1821

HO Use Only / Issue Date:

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

1. Proposed Insured: ☐M Height: _____
   a. Name: _____ ☐F Weight: _____
   b. Date of Birth: _____ Place of Birth: _____
   c. Address: _____
   d. Occupation (When the Proposed Insured is age 16 or older): _____
   e. Name and relationship of Adult Applicant to Proposed Insured when the Proposed Insured is age 15 or less: _____

2. Plan and Face Amount of Insurance: **SPECIAL JUVENILE TERM TO AGE 25**
   $10,000 DOUBLED TO $20,000
   When the Proposed Insured is age 15 or less, the Applicant shall be the Owner of any contract issued. When the Proposed Insured is age 16 or more, the Proposed Insured shall be the Owner of any contract issued.

3. Mode of Premium Payment: _____
   Amount paid with this Application: _____

4. Beneficiary (Show full name and relationship to Proposed Insured):
   a. Primary: _____
   b. Contingent: _____

5. Will the insurance now applied for replace or change any life insurance or annuity?
   Proposed Insured/Applicant: ☐Yes. ☐No. Representative: ☐Yes. ☐No.
   If yes, name of company and policy number: _____

6. Is the Proposed Insured now receiving, or has the Proposed Insured ever received advice, care or treatment for: leukemia, cancer, tumor or malignancy; diabetes; stroke; heart or blood or circulatory disease or disorder; high or low blood pressure; epilepsy, nervous or mental disease or disorder; or, any disease or disorder of the liver, lungs, stomach, intestines, kidneys or genito-urinary system? ☐Yes. ☐No. (If Yes, circle condition and give details in 9 below.)

7. Has the Proposed Insured ever been hospitalized or had hospitalization recommended; or, consulted a medical practitioner for advice or treatment for any illness, injury or other cause? ☐Yes. ☐No. (If Yes, give details in 9 below.)

8. To the best of your knowledge and belief, is the Proposed Insured now in good health and free from any defect or impairment? ☐Yes. ☐No. (If No, give details in 9 below.)

9. Details:

10. Is the Proposed Insured/Applicant a member of the William Penn Association? ☐Yes. ☐No. If No, apply for membership.

Having read, or had read to me, the above statements and answers, I represent that they are true and complete to the best of my knowledge and belief. I understand that this Application shall be the basis for and part of any contract issued.

I UNDERSTAND AND AGREE that no life insurance will take effect unless and until: (1) this Application is approved by the William Penn Association at its Home Office; (2) a contract is issued, delivered to and accepted by me; and (3) the full first premium for the contract is paid. All such conditions must be met while the health and other factors affecting the insurability of the Proposed Insured remain as described in this Application. I agree that the insurance applied for shall be effective on the date assigned by the William Penn Association and shown in the contract.

Signed at: _____ this _____ day of _____ , 20 _____

Signature(s)
Proposed Insured: _____

Adult Applicant: _____

Witness (Licensed Representative): _____ No.: _____

(For Home Office Use: Branch No.: _____ Cert. No.: _____)

Form No. AC-10-86

AUTHORIZATION

I AUTHORIZE any of the following that have any records or information regarding me or any minor child, including driving records or alcohol or controlled substance use or abuse, to provide such records or information to the WILLIAM PENN ASSOCIATION, its legal representative or its REINSURER: (1) a physician or medical practitioner; (2) hospital or clinic, medical or medically related facility; (3) the Medical Information Bureau (MIB); or (4) a consumer reporting or governmental agency or other institution, organization or agency, or employer or person. I understand the records or information so obtained will be used to determine my eligibility, or that of my minor child, for: (1) the insurance applied for; or (2) benefits in the event of a claim.

Except for MIB, all such sources may provide records or information to any organization or agency authorized by the WILLIAM PENN ASSOCIATION to collect such records or information on its behalf. The WILLIAM PENN ASSOCATION or its REINSURER may release information regarding me or my health, or that of my minor child, to: (1) the MIB; (2) an insurer or reinsurer; or (3) as may be lawfully required.

The WILLIAM PENN ASSOCIATION may obtain an investigative consumer report at its discretion.

This Authorization, or a copy, shall be valid for a period of 30 months from the date shown below.

Date: _____

Signature of Proposed Insured or Applicant: _____

SOCIAL SECURITY NO. (Proposed Insured or Applicant): _____

Name of Minor Child: _____

SOCIAL SECURITY NO. (Minor Child): _____

Witness (Licensed Representative): _____

WILLIAM PENN ASSOCIATION
709 Brighton Rd., Pittsburgh, PA 15233-1821 • 412-231-2979 • Fax: 412-231-8535 • Toll-Free: 1-800-848-7366

Authorization to Release Medical Records

PATIENT INFORMATION

Name (Print):_____

Date of Birth:_____ Social Security Number:_____

INFORMATION TO BE RELEASED FROM:

Name of Provider or Facility:_____

Address:_____

INFORMATION TO BE SENT TO: Exam One
800 NW Chipman Rd, Suite 5900, PO Box 2340
Lee's Summit, MO 64063

INFORMATION TO BE RELEASED (Check One):

___ The most recent _____ years of pertinent information (chart notes, labs, x-rays and special tests).

___ All medical records.

___ Specific information (please specify):_____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE (Check One):

_X_ Insurance ___ Attorney ___ Doctor ___ Personal

PATIENT AUTHORIZATION & RIGHTS

I understand and agree that ExamOne and any pharmacy related service organization may disclose my medical records or pharmacy/prescription records and the information contained in those records to 3rd parties, such as insurance companies, or to the representatives of such 3rd parties (including reinsurers and information agencies) for the purpose(s) stated above.

I understand that when my medical records or pharmacy records are disclosed pursuant to this Authorization, my medical/pharmacy records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial):

_____Drug/Alcohol abuse/treatment & diagnosis _____Sexually transmitted disease

_____Mental illness or psychiatric diagnosis/treatment _____HIV/AIDS diagnosis/treatment/testing

I understand I do not have to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment). I understand that I may revoke this Authorization in writing, except to the extent that any health care provider or ExamOne has acted in reliance upon this Authorization.

This Authorization will expire in 90 days from the date signed.

_____ _____

Signature (Patient, Guardian, or Authorized Representative) **Date**

WILLIAM PENN ASSOCIATION

Fraternal Life Insurance and Annuities
709 Brighton Road, Pittsburgh, PA 15233

FRAUD WARNING NOTICE

In accordance with New Jersey law, we must provide you with this notice:

"Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

_____
INSURED'S/APPLICANT'S SIGNATURE

_____
OWNER'S SIGNATURE (if applicable)

NJFW-01/99

WILLIAM PENN ASSOCIATION

709 Brighton Rd., Pittsburgh, PA 15233-1821 • 412-231-2979 • Fax: 412-231-8535 • Toll-Free: 1-800-848-7366

SPWL Illustration Compliance Certification Form

(No Illustration or Non-Matching Illustration)

This form must be signed by the writing agent and applicant/owner, and submitted with any SPWL life application that is not accompanied by a signed Illustration matching the application.

Agent
Check one:

- ☐ No printed Illustration was used during this sale.
- ☐ A printed Illustration was used but does not match the application.

Agent Signature:_____Date_____

Agent Name _____Agent Number _____
(Please Print)

Applicant/Owner

I acknowledge that no Illustration conforming to the applied-for policy was provided.
I understand that an Illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

Applicant/Owner Signature:_____Date_____

Applicant Name: _____Social Security Number_____-_____-_____
(Please Print)

ATTACH TO APPLICATION

WILLIAM PENN ASSOCIATION
A Fraternal Benefit Society
709 Brighton Road, Pittsburgh, PA 15233

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity contract. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed contract and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its representative for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a contract which has been in existence for a period of time may have certain advantages to you over a new contract. If the contract coverages are basically similar, the premiums for a new contract may be higher because rates increase as your age increases. Under your existing contract, the period of time during which the issuing company could contest the contract because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed contract. Your existing contract may have options which are not available under the contract being proposed to you or may not come into effect under the proposed contract until a later time during your life. Also, your proposed contract's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new contract. On the other hand, the proposed contract may offer advantages which are more important to you.

If you are considering borrowing against your existing contract to pay the premiums on the proposed contract, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing contact thereby reducing your total insurance coverage.

After we have issued your contract, you will have 20 days from the date the new contract is received by you to notify us you are canceling the contract issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new contract, examined it and have found it acceptable to you.

Existing Life Insurance or Annuities to be Replaced

Name of Insurer	Name of Insured	Contract Number or Application or Receipt Number

Dated at: _____ this _____ day of _____, 20_____

Signatures

Applicant: _____

Representative: _____

R-1 (2017)

WILLIAM PENN ASSOCIATION

709 Brighton Rd., Pittsburgh, PA 15233-1821 • 412-231-2979 • Fax: 412-231-8535 • Toll-Free: 1-800-848-7366

Original Insurer:_____ Policy Number:_____

Name of Insured: _____ Insured's SS#:_____

Name of Owner: _____ Owner's SS#_____
(if other than Insured)

ABSOLUTE ASSIGNMENT

As the Owner of the policy listed above, I hereby assign and transfer to William Penn Association all right, title and interest in such policy, including but not limited to, the right to surrender the policy. I expressly represent that the sole purpose of this Assignment is to effect an exchange of insurance policies under Section 1035 (a) of the Internal Revenue Code. All policy proceeds will be applied to a contract issued by William Penn Association.

I understand that no insurance with William Penn Association comes into effect as a result of this agreement; and if no William Penn Association policy is issued, I understand that William Penn Association will reassign the above policy to me.

Any death proceeds which may have been paid from the above policy to William Penn Association under the provisions of this assignment shall be deemed to have been received by William Penn Association on behalf of the beneficiary of that policy and shall be distributed to that beneficiary as soon as the beneficiary's right to receive the proceeds has been established.

I understand that William Penn Association is providing this form and is participating in the transaction at my request and as an accommodation to me. I represent that William Penn Association has made no representations concerning my tax treatment under Internal Revenue Code Section 1035 or otherwise and that it has no responsibility or liability to the validity of this assignment or for my tax treatment under Internal Revenue Code Section 1035 or otherwise.

I represent and warrant that no person, firm or corporation has an interest in the policy, except the undersigned, and that no proceedings of either a legal or equitable nature have been instituted or are pending against the undersigned.

I agree that this assignment shall be governed by the laws of the state of residence of the undersigned Owner.

DATED THIS _____day of _____, 20_____ _____
INSURED'S/OWNER'S SIGNATURE

_____ _____
AGENT/WITNESS TYPE OR PRINT INSURED'S/ OWNER'S NAME

The above policy was received for forwarding to William Penn Association at its Home Office in Pittsburgh, Pa.

_____ _____
Date Agent's Signature

INSTRUCTIONS

This form is to be used when the new policy is to be traditional William Penn product. The **ORIGINAL** should be mailed with the current policy to William Penn Association.

ACCEPTANCE FOR TRANSFER/1035 EXCHANGE

(For Home Office Use Only)

The William Penn Association requests liquidation and transfer of the assets of the above referenced policy. By its Authorized Signature below, the William Penn Association will accept the Section 1035 exchange on behalf of the person named on this form. Please provide us with pre-and post-TEFRA cost basis, if applicable.

RECEIVED AND RECORDED BY _____Insurance Company.

Date _____Authorized Signature _____

Form 1035 (Sales) 2013

WILLIAM PENN ASSOCIATION

709 Brighton Rd., Pittsburgh, PA 15233-1821 • 412-231-2979 • Fax: 412-231-8535 • Toll-Free: 1-800-848-7366

DIABETES QUESTIONNAIRE

Name: _____ Date of Birth: _____

Source: _____ Date: _____

1. Name/Address of physician(s) consulted for diabetes? (If Kaiser, obtain patient #)
   Name: _____
   Address: _____
   Date last consulted? _____Details? _____
   _____
   How often do you consult your physician? _____

2. Date diagnosed? _____What were your symptoms? _____
_____

3. Do any of your parents, brothers, sisters have diabetes? ____Yes ____No
_____

4. How is your diabetes controlled? ___Diet ___Oral Medications ___Insulin (circle one)
List medications_____

5. Do you test your own blood sugar? ___Yes ___No How often? _____
Readings? _____

6. Any loss of work or disability associated with diabetes? ___Yes ___No
Details? _____

7. Have you ever had:
   a) Diabetic Coma? ___Yes ___No
   b) Insulin Shock? ___Yes ___No
   c) Heart Trouble? ___Yes ___No
   d) High Blood Pressure? ___Yes ___No
   e) Kidney Trouble? ___Yes ___No
   f) Neuropathy or numbness/tingling? ___Yes ___No
   g) Retinopathy or eye problems? ____Yes ____No

Details: _____

8. Have you ever been hospitalized due to your diabetes? ___Yes ___No
If yes, when and where? _____

9. What is your current HbA1C reading? _____

_____ _____
Signature of the Proposed Insured Date

WILLIAM PENN ASSOCIATION

709 Brighton Rd., Pittsburgh, PA 15233-1821 • 412-231-2979 • Fax: 412-231-8535 • Toll-Free: 1-800-848-7366

BLOOD PRESSURE QUESTIONNAIRE

Applicant's Name:		Date of Birth:
Social Security Number:	Height:	Weight:
Last Doctor's visit:	Any surgeries: ☐ Yes ☐ No	Chiropractor: ☐ Yes ☐ No
Have you ever been hospitalized? ☐ Yes ☐ No Date(s):		Counseling: ☐ Yes ☐ No
Any auto/work related injuries? ☐ Yes ☐ No	Any other medical conditions or medications? ☐ Yes ☐ No	

ANY "YES" ANSWER MUST BE EXPLAINED IN THE NOTES SECTION BELOW.

- When were you first diagnosed with high blood pressure? _____
- Last three blood pressure readings and dates: _____
  _____
- How often is your blood pressure and cholesterol checked by a doctor? _____
- Are you currently taking ANY prescription medications? ☐ Yes ☐ No
  If yes, please list ALL medications, their dosage and frequency. _____
  _____
  _____
- Have you had changes in your blood pressure medication in the past two years?
  ☐ Yes ☐ No
  If yes, please explain. _____
- Is the medication controlling the disorder? _____
- Have you ever been hospitalized for high blood pressure? ☐ Yes ☐ No
- If yes, please list all dates and length of hospitalization. _____
  _____
- Please list your most recent cholesterol level and the date of this test. If above 200, please list your last three readings and the dates of those readings. _____
  _____
- Do you smoke? ☐ Yes ☐ No
  If yes, how much? _____
- Do you have any other medical/health conditions? ☐ Yes ☐ No
  If yes, please list. _____

Have you ever had a diagnostic Stress Test, Echocardiogram, or Heart Catherization? _____Yes _____No

Have you ever been treated or diagnosed with Coronary Artery Disease or had stenting or angioplasty? _____Yes _____No

Notes: _____
_____
_____
_____

To the best of my knowledge, all statements and answers on this questionnaire are complete and true. If any information should result as false or inaccurate, I understand my coverage will be terminated at any time.

_____ _____

Signature Date

WILLIAM PENN ASSOCIATION

709 Brighton Rd., Pittsburgh, PA 15233-1821 • 412-231-2979 • Fax: 412-231-8535 • Toll-Free: 1-800-848-7366

Authorization to WPA for Electronic Funds Transfer (EFT) of Premium Payments From Bank Account

☐ **New Request** ☐ **Change** ☐ **Cancel**

Payor Name(s): _____

Phone No: _____ **Email Address:** _____

Bank Name: _____ **Bank Phone No:** _____

Routing No: ☐☐☐☐☐☐☐☐☐

Account No: _____ ☐ Checking ☐ Savings

Effective Date: _____ ☐ 1st of Month ☐ 15th of Month

EFT Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

This authorization shall apply to the following:

Life or Annuity	Certificate #	Member Name	Amount Authorized
_____	_____	_____	$ _____
_____	_____	_____	$ _____
_____	_____	_____	$ _____

I hereby authorize William Penn Association (WPA) to initiate Electronic Funds Transfer (EFT) payments from my financial institution to pay life insurance and/or annuity premiums, including for any adjustments when necessary, for the certificate(s) specified above.

I understand that:

(1) Notice of EFT payments will not be mailed to me. The transactions will appear on my bank statement.
(2) WPA reserves the right to refuse or terminate electronic payments at any time.
(3) I may change or cancel this authorization by completing a new "Authorization to WPA for Electronic Funds Transfer (EFT) of Premium Payments From Bank Account" form and submitting my completed form to WPA.
(4) Processing of this form may take up to thirty (30) days after it has been received by WPA Treasury Department.
(5) Sufficient funds must be kept in payor's bank account to cover these EFT payments.
(6) If my scheduled withdrawal date is not a business day, the payment will post on the following business day.

YOU MUST INCLUDE ONE OF THE FOLLOWING WITH THIS FORM:

1) If Checking Account: An Original Voided Check (No Starter Checks)
2) If Savings Account: A Letter from your Financial Institution specifying the Bank Account Owner's Name, the Account Number & Routing Number

***** *INCOMPLETE OR INACCURATE APPLICATIONS WILL BE RETURNED* *****

Payor's Signature: _____ **Date:** _____

WILLIAM PENN ASSOCIATION

709 Brighton Rd., Pittsburgh, PA 15233-1821 • 412-231-2979 • Fax: 412-231-8535 • Toll-Free: 1-800-848-7366

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: medical practitioner, physician, hospital, clinic, pharmacy benefit manager or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to WILLIAM PENN ASSOCIATION, or its reinsurers, information concerning advice, care, or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, pharmacy prescription drugs, and/or drug, alcohol or tobacco usage of the applicant(s). I authorize WILLIAM PENN ASSOCIATION, or its reinsurers, to make a brief report of my personal health information to MIB. It is understood that WILLIAM PENN ASSOCIATION underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or 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:

- such information will be used by WILLIAM PENN ASSOCIATION for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- a picture copy or photocopy of this authorization shall be as valid as the original; and
- any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of WILLIAM PENN ASSOCIATION, 709 Brighton Road, Pittsburgh, PA 15233. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

_____
Date

_____
Proposed Insured (Please print)

_____
Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

_____
Birthdate

_____
Additional Proposed Insured (Please print)

_____
Signature of Additional Person Proposed for Insured

_____
Birthdate

_____
Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee, representative, other _____(Circle one)

MIB Pre-Notice

William Penn Association, or our reinsurers, may make a brief report to the MIB, Inc. MIB, Inc. is a not-for-profit membership organization of insurance companies that 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 the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIBs information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The telephone number is 866-692-6901. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

_____ _____

Signature of Applicant Date

(HOME OFFICE COPY)

MIB Pre-Notice

William Penn Association, or our reinsurers, may make a brief report to the MIB, Inc. MIB, Inc. is a not-for-profit membership organization of insurance companies that 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 the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIBs information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The telephone number is 866-692-6901. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

_____ _____

Signature of Applicant Date

(APPLICANT'S COPY)