

SERFF Tracking Number: RNOA-125969828 State: Arkansas
 Filing Company: Royal Neighbors of America State Tracking Number: 41256
 Company Tracking Number: 2086 RNOA-125969828
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Disability Waiver of Monthly Deductions Rider
 Project Name/Number: DWMD/2086

Filing at a Glance

Company: Royal Neighbors of America

Product Name: Disability Waiver of Monthly Deductions Rider SERFF Tr Num: RNOA-125969828 State: ArkansasLH

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 41256

Sub-TOI: L08.000 Life - Other

Co Tr Num: 2086 RNOA-125969828

State Status: Approved-Closed

Filing Type: Form

Co Status: submitted

Reviewer(s): Linda Bird

Authors: John Friederich, Philip Blankenfeld, Deb Zemo, Kelli Zimmer

Disposition Date: 01/08/2009

Date Submitted: 12/31/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: DWMD

Status of Filing in Domicile: Not Filed

Project Number: 2086

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Illinois is projected to be filed 2/2/2009.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 01/08/2009

State Status Changed: 01/08/2009

Deemer Date:

Corresponding Filing Tracking Number: 2086

Filing Description:

This rider is new, and has never been issued by Royal Neighbors of America (Royal Neighbors), nor has it been available for attachment to any life insurance or annuity certificate issued by Royal Neighbors. It is intended that this rider will replace Form 8762, entitled Waiver of Monthly Deductions Rider.

<i>SERFF Tracking Number:</i>	<i>RNOA-125969828</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Royal Neighbors of America</i>	<i>State Tracking Number:</i>	<i>41256</i>
<i>Company Tracking Number:</i>	<i>2086 RNOA-125969828</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Disability Waiver of Monthly Deductions Rider</i>		
<i>Project Name/Number:</i>	<i>DWMD/2086</i>		

This rider will be used with Form 1730 Rev. 10-2008, entitled Application for Permanent Life Insurance, approved for use by your Department on 11/24/2008. This rider will be available for attachment to Form 200911-AR, entitled Flexible Premium Adjustable (universal) Life Insurance Certificate, which was approved by your department on 11/24/2008.

This rider waives the monthly deductions of the universal life certificate in the event of and during total disability of the insured if the disability occurs prior to the certificate anniversary date nearest the insured's 60th birthday.

To the best of my knowledge and belief, no part of this submission contains any unusual or possibly controversial items contrary to normal industry standards. No assumptions or provisions contained in the riders unfairly discriminate in the availability of rates or benefits to individuals of the same class, equal expectation of life, and degree of hazard.

Company and Contact

Filing Contact Information

Debra Zemo, Compliance Assistant/Legal Secretary	zemode@royalneighbors.org
230 16th Street	(800) 627-4762 [Phone]
Rock Island, IL 61201	(309) 788-3887[FAX]

Filing Company Information

Royal Neighbors of America	CoCode: 57657	State of Domicile: Illinois
230 16th Street	Group Code:	Company Type: Life, Health, Annuity
Rock Island, IL 61201	Group Name: Royal Neighbors	State ID Number:
(309) 732-8232 ext. 8232[Phone]	FEIN Number: 36-1711198	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	1 form x \$50 = \$50
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Royal Neighbors of America	\$50.00	12/31/2008	24790220

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	01/08/2009	01/08/2009

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Filing Company: *Royal Neighbors of America* *State Tracking Number:* *41256*
Company Tracking Number: *2086 RNOA-125969828*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *Disability Waiver of Monthly Deductions Rider*
Project Name/Number: *DWMD/2086*

Disposition

Disposition Date: 01/08/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: RNOA-125969828 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Actuarial Demonstration		No
Form	Disability Waiver of Monthly Deductions Rider		Yes

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Form Schedule

Lead Form Number: 2086

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	2086	Policy/Cont Disability Waiver of ract/Fratern Monthly Deductions al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			2086 Disability Waiver of Monthly Deductions Rider.pdf



Disability Waiver of Monthly Deductions Rider

Royal Neighbors of America (Royal Neighbors) has issued this Rider as a part of the life insurance certificate to which it is attached (the Certificate).

BENEFIT – Royal Neighbors will waive the Monthly Deductions (as that term is defined in the Certificate to which this Rider is attached) becoming due under the Certificate upon receipt of proof that Total Disability of the Insured:

1. Began while the Certificate and this Rider are in force; and
2. Exists continuously for at least 6 months ("Waiting Period").

AMOUNT TO BE WAIVED – Subject to the terms of this Rider, Royal Neighbors will waive Monthly Deductions as follows:

1. If Total Disability begins before the Insured is age 60, all Monthly Deductions becoming due after the Waiting Period will be waived; however,
2. Monthly Deductions will continue to be deducted from the Account Value during the Waiting Period; and
3. If, as a result of the continued waiver of Monthly Deductions, the Certificate would exceed the maximum limitation on premiums under IRS guidelines for exclusion of death benefit from gross income on flexible premium life insurance contracts, then no further Monthly Deductions will be waived until such time as additional premiums are permitted under such IRS guidelines.

While Monthly Deductions are being waived under this Rider, the Certificate, including any Riders attached to the Certificate, shall continue in force. Monthly Deductions waived under this Rider will not be deducted from the Certificate proceeds.

DEFINITIONS

Total Disability is defined as:

1. During the first 24 months of Total Disability, the Insured is unable to perform the substantial and material duties of the Insured's regular occupation due to sickness or accidental bodily injury; and
2. After the first 24 months of Total Disability, the Insured is unable to perform the substantial and material duties of the Insured's regular occupation, or any other occupations for which the Insured is reasonably suited by education, training, or experience.

Insured – The term Insured means the person named as the Insured under the Certificate.

NOTICE OF CLAIM – Royal Neighbors must receive written notice of claim and proof of Total Disability ("Notice of Claim"):

1. While the Insured is living;
2. While Total Disability continues or as soon as reasonably possible; and
3. No Monthly Deduction will be waived for any Monthly Deduction that was due more than 1 year prior to the date Notice of Claim is received by Royal Neighbors.

PROOF OF TOTAL DISABILITY – Royal Neighbors reserves the right to require the Insured be examined by physicians satisfactory to Royal Neighbors, at its expense, as a part of proof of Total Disability. Royal Neighbors may also require during the first 24 months, proof of continued Total Disability, but not more frequently than every 30 days. After 24 months, Royal Neighbors may only require proof of continued Total Disability once every 12 months. No Monthly Deduction will be waived if proof is not furnished as required. No proof of continued Total Disability will be required after the Insured reaches attained age 65 if Total Disability began before attained age 60.

The Owner of the Certificate agrees to give Royal Neighbors immediate notice if Total Disability of the Insured should cease. Failure to provide such notice will cancel the coverage provided by this Rider.

EXCLUDED RISKS – Monthly Deductions will not be waived if Total Disability of the Insured results from:

1. Total Disability caused or contributed to by any attempt at suicide, or intentionally self-inflicted injury, while sane or insane;
2. Total Disability caused or contributed to by active participation in a riot, insurrection, or terrorist activity;
3. Total Disability caused or contributed to by committing or attempting to commit a felony;
4. Total Disability caused or contributed to by voluntary intake or use of any means of:
 - a. Any drug, unless prescribed or administered by a physician and taken in accordance with the physician's instructions;
 - b. Poison, gas, or fumes, unless a direct result of an occupational accident;
5. Total Disability occurring after the anniversary of the Issue Date of the Rider on which the Insured attains age 60;
6. Total Disability caused or contributed to by intoxication as defined by the jurisdiction where the Total Disability occurred;
7. Total Disability caused or materially contributed to by participation in an illegal occupation or activity; and/or
8. Total Disability caused or contributed to by any condition disclosed in the application and explicitly excluded in a form attached to the Certificate.

GENERAL – The provisions of the Certificate apply to this Rider unless otherwise provided herein.

ASSIGNMENT – This Rider may not be assigned except in conjunction with and subject to the restrictions contained in the Certificate.

REINSTATEMENT – This Rider may be reinstated under the same terms as the Reinstatement provision of the Certificate.

INCONTESTABILITY – This Rider will be incontestable after it has been in force during the lifetime of the Insured for 2 years from the Issue Date.

NON-FORFEITURE VALUES – This Rider does not have cash or loan values.

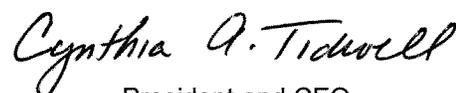
TERMINATION – This Rider will terminate:

1. If the Certificate is continued under a non-forfeiture option;
2. If the Certificate is terminated;
3. Upon written request by the Owner;
4. At the conclusion of this Rider's term;
5. On the death of the Insured; or
6. For nonpayment of premium for this Rider.

The Issue Date of this Rider is shown on Page 3 of the Certificate.

Executed at the Home Office in Rock Island, Illinois on the Issue Date of this Rider.


Secretary and General Counsel


President and CEO

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Rate Information

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice

12/30/2008

Comments:

Attachments:

Compliance Rule and regulation.pdf
Cert of Flesch.pdf

Review Status:

Satisfied -Name: Application

12/30/2008

Comments:

Approved 11/25/08

Attachment:

1730 Rev. 10-2008 Application for Permanent Life Insurance.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: ROYAL NEIGHBORS OF AMERICA

Form Number(s): 2086

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Bruce R. Peterson

Signature of Company Officer

BRUCE R PETERSON

Name

SECRETARY AND GENERAL COUNSEL

Title

12/31/2008

Date



230 16th Street | Rock Island, IL 61201

Phone: (309) 788-4561 | Toll-free: (800) 627-4762
E-mail: contact@royalneighbors.org | Web site: www.royalneighbors.org

CERTIFICATION OF FLESCH READING EASE SCORE

Royal Neighbors of America does hereby certify that the following certificate forms and application, specimen copies of which are submitted herewith, are in its judgment readable based on the factors specified in Arkansas Regulations.

<u>FORM</u>	<u>TITLE</u>	<u>FLESCH SCALE READABILITY ANALYSIS AND TEST SCORE</u>
2086	Disability Waiver of Monthly Deductions Rider	57.4

- A Flesch reading ease test scores of the above forms is as indicated above.
- The forms are printed, except for specification pages, schedules and tables, in not less than ten point, one point leaded.
- The forms listed above were analyzed in their entirety both to the method and formula as specified in Arkansas Regulations.

Dated this 31st day of December, 2008

BY 
Philip K. Blankenfeld – Compliance Manager



A Fraternal Benefit Society

Application for Permanent Life Insurance

PART 1

SECTION 1 – Proposed Insured

Name _____ Street _____
 City _____ State _____ ZIP _____ Years at this address* _____
 SSN/Tax ID _____ *If less than 3 yrs., add prior residence address in additional info, pg 4.
 Phone number () _____ Marital status S M W D Sex M F
 U.S. driver's license Green Card Passport Other _____
 ID number _____ ID issuer _____ DOB _____ State/Country of birth _____
 ID issue date _____ ID expiration date _____ Annual income \$ _____
 E-mail address _____ Employer's name _____
 Position/Title _____
 Duties _____ Length of employment _____
 Are you a U.S. citizen? Yes No Length of citizenship _____ If No, are you a legal U.S. resident? Yes No

SECTION 2 – Other Insurance

1. EXISTING or APPLIED FOR INSURANCE

Does the Proposed Insured have any existing or applied for life insurance (L) or annuity (A) contracts with this or any other company? Yes No **IF YES**, complete and submit state replacement forms, if required, with this application.

Provide details:

Company	Type (L, A)	Amount of Insurance	Year of Issue	Accidental Death Amount	Existing or Applied for
					<input type="checkbox"/> E <input type="checkbox"/> A
					<input type="checkbox"/> E <input type="checkbox"/> A

2. REPLACEMENT

In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (*except conversions*) involving an annuity or other life insurance? Yes No

If Yes, complete and submit a replacement questionnaire **AND** any other state required replacement forms with this application.

SECTION 3 – Proposed Owner/Petitioner*

* Complete if Owner is other than Proposed Insured or Proposed Insured is under age 15½

1. OWNER/PETITIONER

Name _____ Relationship to Proposed Insured _____
 E-mail address _____
 Street _____ U.S. driver's license Green Card Passport
 Other _____
 City _____ State _____ ZIP _____ ID number _____ ID issuer _____
 SSN/Tax ID _____ ID issue date _____ ID expiration date _____
 Phone number () _____ DOB _____

SECTION 4 – Beneficiary(ies)

Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.

PRIMARY

Name _____
 Street _____
 City _____ State _____ ZIP _____
 DOB _____ SSN/Tax ID _____
 Relationship to Proposed Insured _____
 Percent of proceeds _____ %

PRIMARY CONTINGENT

Name _____
 Street _____
 City _____ State _____ ZIP _____
 DOB _____ SSN/Tax ID _____
 Relationship to Proposed Insured _____
 Percent of proceeds _____ %



SECTION 5 – Information Regarding Insurance Applied for

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. PRODUCT NAME _____</p> <p><input type="checkbox"/> Level Pay (<i>to age 121</i>)</p> <p><input type="checkbox"/> Pay to Age 65</p> <p><input type="checkbox"/> 20 Pay</p> <p><input type="checkbox"/> Universal Life</p> <p style="padding-left: 20px;">Death Benefit Type: <input type="checkbox"/> Option A <input type="checkbox"/> Option B</p> <p style="padding-left: 20px;">Planned Premium \$ _____</p> <p><input type="checkbox"/> Other (<i>specify</i>) _____</p> <p>2. FACE AMOUNT \$ _____</p> <p>3. DIVIDEND OPTION</p> <p><input type="checkbox"/> Applied to the payment of current premiums</p> <p><input type="checkbox"/> Paid in cash</p> <p><input type="checkbox"/> Applied to purchase paid-up additional insurance</p> <p><input type="checkbox"/> Left on deposit to accumulate at interest</p> <p>4. Automatic Premium Loan (APL) will be provided.</p> <p><input type="checkbox"/> No Check if APL is NOT desired. (<i>Not applicable to Universal Life</i>)</p> | <p>5. RIDERS</p> <p><input type="checkbox"/> Accelerated Living Benefit Rider (<i>no additional premium</i>)</p> <p><input type="checkbox"/> Accidental Death Face Amount: _____</p> <p><input type="checkbox"/> Guaranteed Insurability Rider</p> <p><input type="checkbox"/> Premium Waiver Disability/Waiver of Monthly Deduction</p> <p><input type="checkbox"/> Spousal Rider</p> <p style="padding-left: 20px;">*Please complete Supplemental Application</p> <p style="padding-left: 20px;">Spouse's Full Name _____</p> <p><input type="checkbox"/> Child Rider</p> <p><input type="checkbox"/> Flexible Premium Deferred Annuity Rider</p> <p style="padding-left: 20px;">Planned Premium _____</p> <p style="padding-left: 20px;">(<i>Mode will be the same as base certificate.</i>)</p> <p><input type="checkbox"/> Other (<i>specify</i>) _____</p> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

SECTION 6 – Payment Information

If **Electronic Payment** is chosen, complete Pre-Authorized Collection (PAC) form on page 6.

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. PAYMENT MODE (<i>Check one</i>)</p> <p>Direct bill: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly</p> <p>Electronic payment: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual</p> <p style="padding-left: 20px;"><input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> Payment with app \$ _____ <input type="checkbox"/> Draft first payment</p> <p>Additional details _____</p> <p>_____</p> | <p>2. BILLING ADDRESS INFORMATION</p> <p><input type="checkbox"/> Proposed Insured's address <input type="checkbox"/> Proposed Owner/Petitioner's address</p> <p><input type="checkbox"/> Other Premium Payor's/Alternate billing address (<i>details below</i>)</p> <p>Name _____</p> <p>Street _____</p> <p>City _____ State _____ ZIP _____</p> <p><input type="checkbox"/> Special arrangements _____</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

SECTION 7 – General Risk Questions

Has the Proposed Insured:

(Provide details to questions in Additional Information section on page 4)

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. In the past 5 years, done any flying other than as an airline passenger or engaged in vehicle racing, underwater diving, or sky diving? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Any current or expected duties with the Armed Forces? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. In the past 5 years, used tobacco products? If Yes, identify what was used, how much, and dates of usage. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. In the past 5 years, been convicted of one or more vehicle moving violations, driving under the influence of alcohol or drugs, or ever had a driver's license revoked or suspended? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Ever had an application for life or health insurance declined, postponed, up-rated or modified, or any insurance cancelled or its renewal refused? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Ever claimed disability benefits for an injury, illness, or impaired condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Been convicted of a felony? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Any plans to travel or reside outside the U.S.? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Entered into any agreement or arrangement providing for the future sale of the insurance certificate applied for in this application? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Entered into any agreement or arrangement where the Proposed Insured will receive financing or a loan, including forgivable loans, to pay some or all of the premiums, costs or other expenses associated with this loan? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Entered into any agreement either orally or in writing by which you are to receive any form of consideration in exchange for procuring the insurance certificate you are applying for? | <input type="checkbox"/> Yes <input type="checkbox"/> No |



SECTION 1 – Physician Information

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning the present health of the Proposed Insured.

Check here if no doctor, practitioner, or health care facility is known.

Physician name _____ Name of practice/clinic _____

Street _____ City, State, ZIP _____

Phone number () _____ Fax number () _____

Date last consulted _____ Provide reasons for treatments and the results. _____

List all currently prescribed medications, dosage, and frequency. _____

SECTION 2 – Medical Questions

1. Height _____ Weight _____ Experienced a change in weight (*greater than 10 pounds*) in the last 12 months? Yes No

If Yes, specify: Pounds lost _____ Pounds gained _____ Reason _____

2. Are your parents (*P*) or any siblings (*S*) deceased or ever had heart disease, diabetes, cancer, or mental illness? Yes No

If Yes, indicate below:

Relationship	Age at death	State of health, specific conditions, cause of death
<input type="checkbox"/> P <input type="checkbox"/> S		
<input type="checkbox"/> P <input type="checkbox"/> S		
<input type="checkbox"/> P <input type="checkbox"/> S		

3. Have you received counseling or treatment from any physician for, or been convicted for, the use of alcohol or the use and/or possession of drugs? Yes No

4. Have you used amphetamines, barbiturates, cocaine, narcotics, marijuana, or other depressant, excitant, or hallucinatory drugs, unless administered on the advice of a physician? Yes No

5. Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (*AIDS*), AIDS Related Complex (*ARC*), or the Human Immunodeficiency Virus (*HIV*)? Yes No

6. Have you during the past 10 years, been diagnosed as having, been treated by a member of the medical profession for, or tested positive for:

A. Heart attack; high blood pressure; stroke; or other disorder of the heart or blood vessels? Yes No

B. Cancer, tumor, cyst, mass; leukemia; lymph gland; thyroid; chronic fatigue; or any other blood abnormalities? Yes No

C. Diabetes or other endocrine disorder; sugar, albumin, or blood in urine; stone or other disorder of kidney, bladder, or prostate? Yes No

D. Lung or chronic respiratory disorder; asthma; bronchitis; emphysema; pneumonia; tuberculosis; or any other disorder of the respiratory system? Yes No

E. Intestinal bleeding; ulcer; hepatitis; or other disorder of stomach, liver, intestine, or gallbladder? Yes No

F. Any disease or disorder of the reproductive organs or breasts? Yes No

G. Brain, mental, or emotional nervous disorder; fainting; convulsions; paralysis; depression; anxiety; frequent recurring headaches; any other disease or disorder of the nervous system; attempted suicide; or ever been counseled for any of the above? Yes No

H. Arthritis; gout, loss of limb, or deformity; disorder of bone, joint, muscle, back, or spine; skin disorder; or any other disorder of the skeletal system? Yes No

I. Disease or disorder of eye, ears, nose, or throat? Yes No

J. Any diagnostic test, such as an electrocardiogram, x-ray, MRI, CT scan, biopsy, or blood study? Yes No

K. Any surgery? Yes No

L. Advised to have any diagnostic test, hospitalization, or surgery which has not been completed? Yes No

M. Treatment as an inpatient or outpatient or is currently confined in a hospital, institution, clinic, sanatorium, or other medical facility? Yes No



SECTION 2 – Medical Questions (cont.)

Details: If you answered YES to any of the medical questions above, please provide details here.

Question Number	Name of Physician Address if not already provided	Date/Duration of Illness	Diagnosis/Severity Medications/Treatments

Additional Information

Use this section for any additional information. Attach a separate sheet if necessary.

Agreement/Acknowledgement

Agreement/Disclosure

We, the Proposed Insured, Proposed Owner, or Proposed Petitioner, if applicable, have read this application for life insurance including any amendments and supplements and, to the best of our knowledge and belief, all statements are true and complete.

We also agree that:

- Statements in this application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any certificate issued.
- This application and any amendment(s), paramedical/medical exam, and supplement(s) to this application will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors of America (*Royal Neighbors*), become part of the new certificate, and any copy or electronic image of these documents are as valid as the original and may be relied upon by Royal Neighbors in determining whether to issue the insurance for which I applied.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in this application and amendment(s), paramedical/medical exam, and any supplement(s).
- Only authorized officers of Royal Neighbors may: a) make or change any contract of insurance; b) make a binding promise about insurance; or c) change or waive any term of an application, receipt, or certificate.
- Corrections, additions, or changes to this application may be made by Royal Neighbors. Any such changes will be shown under "Corrections and Amendments." Acceptance of a certificate issued with such changes will constitute acceptance of the changes. No change will be made in classification (*including age at issue*), plan, amount, or benefits unless agreed to in writing by the Applicant.
- Unless otherwise provided by the Conditional Receipt, Royal Neighbors will have no liability under this application unless and until: a) it has been received and approved by Royal Neighbors at its Home Office; b) the certificate has been issued and delivered to the certificateowner; c) the first premium has been paid to and accepted by Royal Neighbors; and d) at the time of delivery and payment, the facts concerning the insurability of the Insured are as stated in this application.
- If not a current member, the Proposed Insured applies to become a member of Royal Neighbors as indicated by the signature on page 5, and as a member, agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors of America was founded more than 100 years ago.

Taxpayer Identification Number Certification

Under penalties of perjury, We, the Proposed Insured, or Parent, if a minor, or Proposed Owner, if applicable, certify that:

1. The number shown on this form is my correct taxpayer identification number (*or I am waiting for a number to be issued to me*), and
- 2 a. **Proposed Insured** – I am not subject to backup withholding because: a) I am exempt from backup withholding, or b) I have not been notified by the Internal Revenue Service (*IRS*) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding, and
- b. **Proposed Owner** – I am not subject to backup withholding because: a) I am exempt from backup withholding, or
- b) I have not been notified by the Internal Revenue Service (*IRS*) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person.

Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. The IRS does not require your consent to any part of this form other than the certifications required to avoid backup withholding.



Authorization

I, the Proposed Insured, or Parent, if a minor, hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), consumer reporting agency, division of motor vehicles, the veterans administration, or other government agency or department having information as to the diagnosis, treatment, or prognosis with respect to any physical or mental condition, or having any non-medical information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past 10 years, without restriction, to Royal Neighbors, its agents, employees, representatives, or its reinsurers. This includes information on the treatment of alcohol, drug, and tobacco abuse, and psychiatric diagnosis and treatment. **In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, to give such information to any legal representative or agent employed by Royal Neighbors.**

I understand that the protected information is to be disclosed under this authorization so that Royal Neighbors may underwrite my application for life insurance, determine my eligibility for insurance, risk rating, or certificate issuance determinations, obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have applied for with Royal Neighbors. Any protected information obtained will not be released by Royal Neighbors or its reinsurers to any person or organization EXCEPT to other divisions and/or departments of Royal Neighbors or its reinsuring companies, MIB, other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted, or other persons or organizations performing business or legal services in connection with my application, insurance certificate(s), or claim for benefits or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for 24 months from the date signed if used in connection with an application for life insurance certificate, an application for reinstatement of a life insurance certificate, or a request for change in certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative is entitled to receive a copy. I understand that this authorization may be revoked by me at any time in writing, and if I refuse to sign or if I subsequently revoke this authorization, Royal Neighbors may not be able to process this application, and if coverage has been issued, may not be able to process any benefit payments. I agree that Royal Neighbors shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation at its Home Office or to the extent that Royal Neighbors has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be re-disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

Check here if a copy of this authorization is desired.

Corrections and Amendments *(For Home Office Use Only)*

By checking this box I (we) understand that I (we) have elected to draft first premium from a financial institution. I (We) understand that there will be no insurance coverage unless and until the insurance applied for has been issued, delivered, and the first draft has been honored by the financial institution.

SIGNATURES:



Signed at city, state _____ Date _____

Proposed Insured _____
(Sign if age 12 or older)



Signed at city, state _____ Date _____

Proposed Owner/Petitioner _____



Signed at city, state _____ Date _____

Signature of Parent _____
(Required for all applicants under age 18)



Signed at city, state _____ Date _____

Proposed Insured Spouse _____
(Sign if Spousal Rider applied for)



Agent's Report

REPLACEMENT:

Do you have any knowledge or reason to believe the Proposed Insured has any existing or applied for life insurance or annuity contracts with this or any other company? Yes No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? Yes No

Do you have any knowledge or reason to believe that the Proposed Insured has in-force life insurance or annuity contracts that may be replaced as a result of this transaction? Yes No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? Yes No

Did you use only written sales material approved for use by Royal Neighbors? Yes No

Did you personally review the I.D. of the Owner? Yes No If Yes, form of I.D. _____

Agent no. _____ Agent license no. _____ Agent chapter no. _____



Signature of Writing Agent _____ Date _____

Printed name of Writing Agent _____

If applicable, complete and sign the following statement(s):

Agent Signature _____ Date _____

Agent Name _____ ID Number _____ Percent _____
Please print

Agent Signature _____ Date _____

Agent Name _____ ID Number _____ Percent _____
Please print



A Fraternal Benefit Society

INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES™

Authorization for Pre-Authorized Collection Plan

I authorize Royal Neighbors of America (*Royal Neighbors*) and the financial institution named below to initiate automatic withdrawals from my checking/savings account. This authority will remain in effect until I notify Royal Neighbors or the bank to cancel it in such time as to afford a reasonable opportunity to act on the request. I can stop payment of any withdrawal by notifying Royal Neighbors three days before my scheduled withdrawal day. Royal Neighbors reserves the option to change the method of payment to another qualifying mode after the occurrence of a transaction not honored.

Name of financial institution _____ City _____ State _____

Name (*please print*) _____ Phone number () _____

Street address/PO Box _____

City _____ State _____ ZIP _____

I would like the payment withdrawn on the _____ (*select from the 1st through 28th*) day of the month.

Checking account no. _____ OR Savings account no. _____

If this box is checked I authorize you to immediately withdraw at least one month's premium at the premium class applied for from my account.



Signature as it appears on bank records _____ Date _____

PLEASE RETURN THIS AUTHORIZATION WITH A VOIDED CHECK OR A DEPOSIT SLIP





A Fraternal Benefit Society

Conditional Receipt

Unless each and every condition specified in paragraph 1 below is fulfilled exactly, no insurance will become effective prior to delivery of the certificate of insurance. No agent of Royal Neighbors of America (*Royal Neighbors*) is authorized to alter or waive any of the conditions.

Received from _____ on (Date) _____ the sum of \$ _____ / no money received with application in connection with an application to Royal Neighbors for the following insurance certificate:

Proposed Insured: _____ Life Insurance Amount: \$ _____ Plan: _____

1. All of the following conditions must be met before insurance may become effective prior to delivery of the certificate:
 - a) The payment indicated above must be at least equal to one month's premium at the premium class applied for. Assuming all other conditions under this paragraph have been met, if Royal Neighbors, in accordance with its rules, would have issued the certificate under a different premium class than applied for, and the premium paid was less than the premium that would have been required for the issuance of a certificate at this new premium class, then the death benefit payable under the receipt shall be such as the premium paid would have purchased at the new premium class.
 - b) All medical examinations and tests required by Royal Neighbors must be completed and received at the Home Office of Royal Neighbors.
 - c) As of the effective date, as defined below, the Proposed Insured must be a standard risk under rules and practices of Royal Neighbors for the plan and the amount of life insurance applied for, without change and at the rate of premium paid.
 - d) As of the effective date, the state of health and all factors affecting the insurance of the Proposed Insured must be as stated in the application.
2. When each and every one of the conditions of paragraph 1 have been met, the insurance coverage, as provided by the terms and conditions of the certificate of life insurance applied for, but for an amount not exceeding \$400,000, will begin as of the Effective Date. "Effective Date" as used herein, means the later of:
 - a) the date of completion of the application; or
 - b) the date of completion of all medical examinations, electrocardiograms, x-rays, and other tests required by Royal Neighbors.
3. If the conditions have been met and coverage begins, coverage under this receipt will terminate 60 days from the date of this receipt unless prior to that date the insurance certificate is issued and accepted.

IMPORTANT INFORMATION: If no check or money order is received with this application, then this conditional insurance is not effective and there will be no insurance in effect unless and until a certificate for the insurance applied for has been issued and the first premium due has been paid in full.



Signature of Agent Receiving the Payment _____



Signature of Proposed Insured _____

I understand and agree to the terms, conditions, and limits of this receipt and the agreements in the application, all of which have been fully explained to me by the agent.



Signature of Proposed Owner/Petitioner _____

Royal Neighbors of America

www.royalneighbors.org

Rock Island, Home Office

230 16th St., Rock Island, IL 61201

(800) 627-4762



Important Information for Applicant

Arizona: On written request, Royal Neighbors of America will provide the certificateowner with information regarding the provisions of the life insurance certificate. If for any reason the certificateowner is not satisfied with the life insurance certificate, she/he may return the certificate to Royal Neighbors of America within 20 days (*30 days if the certificateowner is 65 years of age or older*), after receiving the certificate and receive a refund of all monies paid.

Arkansas, California, New Mexico, Texas, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurer for the purpose of defrauding or attempting to defraud the insurer. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurer or agent of an insurer who knowingly provides false, incomplete, or misleading facts or information to a certificateowner or claimant for the purpose of defrauding or attempting to defraud the certificateowner or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia and Georgia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Indiana and Oklahoma: Any person who knowingly, with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Kentucky and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

Ohio: Any person who, with intent to defraud, or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Tennessee, Washington, and Maine: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company (*insurer*) for the purpose of defrauding the insurer. Penalties include imprisonment, fines, and denial of insurance benefits.

Medical Information Bureau, Inc. (MIB), Notice

This Notice is to be detached, read, and retained by the Proposed Insured

Information regarding your insurability will be treated as confidential. Royal Neighbors or its reinsurers make a brief report thereon to the Medical Information Bureau, 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 if a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901, TTY (866) 346-3642. 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 Report Act. The address of MIB's information office is: MIB, P.O. Box 105, Essex Station, Boston, MA 02112.

Royal Neighbors or its reinsurers may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

Fair Credit Report Act Notice

This is to inform you that as part of our underwriting procedures in connection with this application, an investigative consumer report may be obtained on the Proposed Insured and the Proposed Petitioner. This report will provide applicable information concerning character, general reputation, personal characteristics, and mode of living.* This information will be obtained through personal interviews with neighbors, friends, and associates. You may request to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. No information collected concerning the sexual orientation of the Proposed Insured or Proposed Petitioner will be used to determine her or his eligibility for life insurance.

**Information obtained will not be used to determine sexual orientation.*

