

<i>SERFF Tracking Number:</i>	<i>CAKN-126705325</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Catholic Knights</i>	<i>State Tracking Number:</i>	<i>46121</i>
<i>Company Tracking Number:</i>	<i>17-710</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Whole Life</i>		
<i>Project Name/Number:</i>	<i>CNO-17 ss/17-710</i>		

## Filing at a Glance

Company: Catholic Knights	SERFF Tr Num: CAKN-126705325	State: Arkansas
Product Name: Whole Life	SERFF Status: Closed-Approved-	State Tr Num: 46121
TOI: L071 Individual Life - Whole	Closed	
Sub-TOI: L071.101 Fixed/Indeterminate	Co Tr Num: 17-710	State Status: Approved-Closed
Premium - Single Life		
Filing Type: Form	Author: Donna Peterson	Reviewer(s): Linda Bird
	Date Submitted: 07/02/2010	Disposition Date: 07/07/2010
		Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

## General Information

Project Name: CNO-17 ss	Status of Filing in Domicile: Pending
Project Number: 17-710	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments: Wisconsin, our state of domicile, is part of the Inter-state compact. This filing is pending in with the Compact.
Explanation for Combination/Other:	Market Type: Individual
Submission Type:	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/07/2010	Explanation for Other Group Market Type:
	State Status Changed: 07/07/2010
Deemer Date:	Created By: Donna Peterson
Submitted By: Donna Peterson	Corresponding Filing Tracking Number:
Filing Description:	
We are a Fraternal Insurance Society filing a Whole Life Insurance product form number 2010 WL AR. This is a Single Life, fixed premium product. It will be used with application 2010 LF APP (part 1 & 2) approved by your state on June 16, 2010. (SERFF No. FRCA- 126669811). It will be illustrated.	

SERFF Tracking Number: CAKN-126705325 State: Arkansas  
 Filing Company: Catholic Knights State Tracking Number: 46121  
 Company Tracking Number: 17-710  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Whole Life  
 Project Name/Number: CNO-17 ss/17-710

**Forms included with this filing:**

- 1) WL contract form no.: 2010 WL AR; and
- 2) Waiver of Premium Rider form no.: 2010 WP WL.

Two additional term riders will be used with this product:

- 1) Children's Term Rider form no.: 2010 CHLD TRM RDR and
  - 2) Additional Insured 20 Yr Level Term Rider form no.: 2010 20 YR2 TRM RDR
- They were filed with your state and approved July 1, 2010, (SERFF No. CAKN-126675997).

## Company and Contact

### Filing Contact Information

Donna Peterson, donna.p@cflife.org  
 1100 W Wells Street 414-278-6509 [Phone]  
 Milwaukee, WI 53233

### Filing Company Information

Catholic Knights CoCode: 56030 State of Domicile: Wisconsin  
 1100 West Wells Street Group Code: Company Type: Fraternal  
 Milwaukee, WI 53233 Group Name: State ID Number: 2796  
 (414) 273-6266 ext. 6468[Phone] FEIN Number: 39-0201015

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Catholic Knights	\$100.00	07/02/2010	37724469

SERFF Tracking Number: CAKN-126705325

State: Arkansas

Filing Company: Catholic Knights

State Tracking Number: 46121

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TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Whole Life

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/07/2010	07/07/2010

*SERFF Tracking Number: CAKN-126705325*

*State: Arkansas*

*Filing Company: Catholic Knights*

*State Tracking Number: 46121*

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*TOI: L071 Individual Life - Whole*

*Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life*

*Product Name: Whole Life*

*Project Name/Number: CNO-17 ss/17-710*

## **Disposition**

Disposition Date: 07/07/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CAKN-126705325 State: Arkansas  
 Filing Company: Catholic Knights State Tracking Number: 46121  
 Company Tracking Number: 17-710  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Whole Life  
 Project Name/Number: CNO-17 ss/17-710

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Reg 19 certification		Yes
Form	Whole Life Insurance		Yes
Form	Waiver of Premiums		Yes

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 Filing Company: Catholic Knights State Tracking Number: 46121  
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 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Whole Life  
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## Form Schedule

### Lead Form Number: 2010 WL

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	2010 WL AR	Policy/Cont Whole Life Insurance Initial ract/Fraternal Certificate	Initial		53.000	WL AR fld vrsn 6-28.pdf
	2010 WP WL	Certificate Waiver of Premiums Amendment, Insert Page, Endorsement or Rider	Initial		50.500	2010 WP WL (Rider).pdf



[CATHOLIC KNIGHTS]  
1100 West Wells Street  
Milwaukee Wisconsin 53233  
800-927-2547  
[www.catholicknights.org]

Insured: [John Doe]  
Certificate Number: [123456]

**WHOLE LIFE INSURANCE**

Insurance Payable at Death of Insured  
Premiums Payable for Stated Period  
Schedule of Benefits and Premiums in Section 1  
Participating

**READ YOUR CONTRACT CAREFULLY** This is a legally binding insurance contract between you and [Catholic Knights]. The contract is issued based on the signed application and receipt of the full payment of the initial premium.

[Catholic Knights] agrees to pay the benefits provided in this contract subject to its terms and conditions upon receipt of due proof of the insured's death. We will pay the insurance proceeds (see Section 3.1) to the beneficiary according to the provisions of this certificate.

**RIGHT TO CANCEL** – The owner may cancel this contract for any reason before midnight on the twentieth (20<sup>th</sup>) day after the owner received the certificate. If the contract is a replacement contract the owner may cancel this contract for any reasons before midnight on the thirtieth (30<sup>th</sup>) day after receipt of the certificate.

This is done by delivering or mailing a written notice and the certificate to [Catholic Knights], 1100 West Wells Street, Milwaukee, Wisconsin 53233, to our authorized agent through whom you purchased the insurance, or to any [Catholic Knights] authorized agent. If mail is used, it is effective on the date postmarked with a correct address and sufficient postage. [Catholic Knights] will return all payments for this insurance within ten (10) days after it receives the notice and the certificate. This contract will then be void from the beginning.

Signed at our Home Office in Milwaukee, Wisconsin, on the certificate date.

[  
[ *William R. O'Toole*                      *Allan S. Joyce* ]  
President    Secretary ]

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**SECTION 1 CONTRACT SPECIFICATIONS**

**INSURED:** [John D. Doe]  
**ISSUE AGE:** [35]                      **SEX:** [male]

**FACE AMOUNT OF INSURANCE:** [\$100,000]  
**CERTIFICATE NUMBER:** [1234567]

**CERTIFICATE DATE:** [7/1/2010]

**PREMIUM CLASS:** [NON-TOBACCO]  
**[RISK CLASS: TABLE 4]**

**OWNER:** [John D. Doe]

**DIVIDEND OPTION** [Left on Deposit]

**CONTRACT LOAN INTEREST** [7%]

**EFFECTIVE ANNUAL INTEREST RATE FOR REINSTATEMENT:** 6%

**SCHEDULE OF BENEFITS AND PREMIUMS**

<u>DESCRIPTION</u>	<u>BENEFIT AMOUNT</u>	<u>ANNUAL PREMIUM</u>	<u>No. Yrs PREMIUM PAYABLE</u>	<u>EXPIRES ON CONTRACT ANNIVERSARY DATE</u>
Whole Life	[\$100,000]	[\$851.00]	Life	[2096]
Waiver of Premium Rider		[\$37.00]	[30]	[2040]

**TOTAL PREMIUMS**

These premiums include the charge for any additional benefits

<b>ANNUAL</b> [\$888.00]	<b>SEMIANNUAL</b> [\$461.76]	<b>EFT (MONTHLY)</b> [\$73.97]
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**PREMIUM PAYMENT METHOD:** [ANNUAL]

**DIVIDENDS** are not guaranteed. We do not expect that any dividend will be paid for this contract until at least two (2) years from the certificate date.

**BENEFICIARY** As stated in the application unless subsequently changed as provided in this contract.

The effective date and issue age of each benefit is the certificate date and issue age provided in the certificate, unless otherwise specified.

The telephone number of the [AR Department of Insurance is 501-371-2600]

## SECTION 2. DEFINITIONS

**YOU** and **YOUR** refer to the owner of this insurance contract. The owner is as shown in Section 1, unless later changed as provided in this contract. The owner may be someone other than the insured.

**WE, US** and **OUR** means [Catholic Knights], a fraternal benefit society.

**AGE** means the age of the insured on his or her last birthday.

The **BENEFICIARY** is the person who has a right to receive the death benefit proceeds.

The **CERTIFICATE DATE** is the date this contract goes into effect. It is shown in Section I.

The **CONTRACT** is this certificate, together with the application and any riders. Our Amended and Restated Articles of Incorporation and Bylaws also are part of the contract.

**CONTRACT YEARS, ANNIVERSARIES** and **MONTHS** are measured from the certificate date shown in Section 1. For example, if the certificate date is September 1, 2010, the first year ends August 31, 2011. Contract anniversary means the same month and day as the contract date for each year the contract remains in force. The first contract year begins on the contract date and ends at 11:59 p.m. on the day prior to the first contract anniversary. Subsequent contract years begin on a contract anniversary and end at 11:59 p.m. on the day prior to the next contract anniversary.

**IN FORCE** means the insured's life remains insured under the terms of this contract. This contract is in effect.

The **INSURED** is the person named in Section 1 at whose death the insurance proceeds will be payable.

A **RIDER** is an attachment to the contract. It provides additional benefits.

**TERMINATE** means the insured's life is no longer insured under any of the terms of this contract. This contract is no longer in effect.

**WRITTEN** A written request or statement signed by you and received in good order by us at our Home Office.

To make this certificate clear and easy to read, we have left out many cross references and conditional statements. Therefore, the provisions of the certificate must be read as a whole.

## **SECTION 3 GENERAL PROVISIONS**

### **3.1 Insurance Proceeds**

When the insured dies, an amount of money, called the insurance proceeds, is payable to the beneficiary. The insurance proceeds are the total of:

- The Face Amount of Insurance  
PLUS
- Any insurance on the insured's life which may be provided by riders to this contract
- Any insurance bought with dividends
- Any dividends left with us to earn interest
- Any part of a premium paid for coverage beyond the contract month in which the insured dies;  
MINUS
- Any premium due
- Any indebtedness

### **3.2 Payment of Interest on the Insurance Proceeds**

- a. The insurance proceeds will be paid to the beneficiary within one month after we receive due proof of the insured's death and the claimant's right to payment. We will pay the insurance proceeds in one lump sum unless one or more of the optional payment plans described in Section 10 are selected.
- b. We will pay interest on the proceeds from the date of death to the date of settlement at the rate paid on the date of death for funds left on deposit with us.
- c. Interest shall accrue at the effective annual rate determined in Item (b) above, plus additional interest at a rate of 10% annually beginning with the date that is 31 calendar days from the latest of Items (i), (ii) and (iii) to the date the claim is paid, where it is:
  - (i) The date that due proof of death is received by the society;
  - (ii) The date the society receives sufficient information to determine its liability, the extent of the liability, and the appropriate payee legally entitled to the proceeds; and
  - (iii) The date that legal impediments to payment of proceeds that depend on the action of parties other than the society are resolved and sufficient evidence of the same is provided to society. Legal impediments to payment included, but are not limited to (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; and (c) the submission of information required to satisfy a state and federal reporting requirements.

### **3.3 The Contract**

This contract is issued in consideration of:

- a. your application;
- b. the payment of premiums; and
- c. the contract and rider provisions.

The entire contract consists of:

- a. this certificate;
- b. any additional benefits provided by rider;
- c. the attached application;
- d. any required medical examination or declaration of insurability; and
- e. our Amended and Restated Articles of Incorporation and Bylaws, as amended from time to time.

No change in our Articles of Incorporation or Bylaws as amended made after the contract date shall reduce or change the benefits promised in this contract. You may continue this contract in force even if membership in the [Catholic Knights] is terminated except for nonpayment of premium or within the contestable period for material misrepresentation in the application. No provision in the Articles or Bylaws provides for the termination of coverage under this contract.

All statements made by the applicant for issuance, reinstatement or renewal of this contract shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement, unless made in the application, to void this contract or to deny a claim.

No agent or person other than the President or Secretary has the authority to change or modify this contract or waive any of its provisions.

### **3.4 Incontestability**

This Contract will not be contested by us after it has been in force during the lifetime of the Insured for two (2) years from the Certificate Date except for (a) non-payment of premium, and (b) fraud in the procurement of this Contract when permitted by applicable law in the state where this contract is delivered or issued for delivery.

This provision will apply from the date this Contract is reinstated with regard to statements made in the application for reinstatement.

### **3.5 Suicide**

If the insured dies by suicide, whether sane or insane within two years of the contract date, the only amount payable to the beneficiary will be the sum of the premiums paid without interest less any indebtedness.

### **3.6 Misstatement of Age or Sex**

If the age or sex of any insured has been misstated, the amount payable will be the amount which the premiums paid would have purchased at the correct age and sex.

### **3.7 Maintenance of Legal Reserves**

The reserves held on your contract are computed according to the standards prescribed by law. If, for any reason at any time, we do not have sufficient assets to cover the reserves, the Board of Directors may require that the amount of such deficiency shall be equitably apportioned to all outstanding policies. The amount thus apportioned to your contract shall either:

- a. be paid in cash by you; or
- b. be an indebtedness against your contract at a rate of interest of eight percent ( 8%) per annum; or
- c. with owner consent be an equivalent reduction in benefits.

### **3.8 Termination**

The contract will terminate:

- a. when we receive written notice to terminate; or
- b. when the insured dies; or
- c. if any premium due is unpaid at the end of the grace period; or
- d. on the expiry date shown in Section 1.

### **3.9 Forms and Procedures**

We may require the owner to follow our procedures and to use our forms to take any action, such as changing a beneficiary or requesting a payment. We may require the owner to submit this certificate for endorsement to show any change. The owner may obtain any information and forms from an authorized agent or the home office.

## **SECTION 4. OWNERSHIP**

### **4.1 The Owner**

The owner is named on page 3. The owner may exercise all contractual rights during the lifetime of the insured, without the consent of any beneficiary unless the beneficiary has been made irrevocable. These rights may be exercised only during the lifetime of the insured.

### **4.2 Transfer of Ownership**

You may transfer the ownership of this contract during the lifetime of the insured. Written evidence of transfer satisfactory to us must be received at our home office. The transfer will then be effective as of the date it was signed subject to any payments made or actions taken by the society prior to receipt of the transfer.

### **4.3 Successor Owner**

The contract owner may designate a successor owner to assume the responsibilities and duties of the contract owner in the event of the death or disability of the contract owner. The successor owner may be an individual, at least 18 years of age, or a corporation, partnership, trust or other entity. The successor owner has no rights in regard to the contract and cannot direct any changes, conversion, transfers or cancellations, except in the event of the death of the contract owner. The contract owner may change the designation of the successor owner at any time.

#### **4.4 Collateral Assignment**

You may assign this Contract as collateral security. We assume no responsibility for the validity or effect of any collateral assignment of this Contract. We will not be responsible to an assignee for any payment or other action taken by us before receipt of the assignment in writing at our Home Office.

The interest of any beneficiary will be subject to any collateral assignment made either before or after the beneficiary designation. The rights of an assignee may not come before the rights of an irrevocable beneficiary that is designated prior to the assignment.

You must give us notice of an assignment. An assignment, unless otherwise specified by the owner, will be effective on the date signed, subject to any payments made or actions taken by us prior to receipt of such notice.

A collateral assignee is not an owner. A collateral assignment is not a transfer of ownership. Ownership can be transferred only by complying with Section 4.2.

### **SECTION 5. PREMIUMS AND REINSTATEMENT**

#### **5.1 Premium Amount**

**A. PAYMENT** The first premium is due and must be paid as of the certificate date. All premiums are payable at our home office or to an authorized agent. A premium must be paid on or before its due date (see page 3). If you want a receipt for premium payment, we will provide one upon request.

**B. FREQUENCY** Premiums may be paid annually, semiannually, or monthly by electronic funds transfer (EFT) at our published rates. A change in premium frequency will be effective upon our acceptance of the premium for the new frequency. Premiums may be paid on any other frequency approved by us.

**C. GRACE PERIOD** A 31-day grace period will be allowed for payment of a premium not paid on its due date. This contract will continue in full force during this period. If the premium is not paid within the grace period, the contract will terminate as a lapse as of the due date. If the insured should die during the grace period, the amount of any due and unpaid premium will be deducted from the proceeds.

#### **5.2 Premium Due Date**

The due date for the first premium is the certificate date as listed on page 3. The due date for subsequent premiums is the first day of each contract year thereafter for the annual mode, or the first day of each contract month thereafter for the electronic funds transfer (EFT) mode. The due date for the other modes is the first day of the contract month following the modal time period. For example, the second due date for the semiannual mode is the first day of the seventh contract month.

#### **5.3 Reinstatement**

You may reinstate this contract within three years (3) after the due date of the unpaid premium if the Insured is still alive and the contract has not been surrendered. Within 29 days following the end of the grace period, we will reinstate the contract upon payment of the overdue premium.

After that 29-day period, we will reinstate the contract if you:

- a. Provide evidence of insurability satisfactory to us; and
- b. Repayment or reinstatement of all indebtedness existing at the end of the Grace period.
- c. Payment of all overdue premiums with interest from the due date of each premium. Interest is at a rate of six percent (6%) compounded annually, or any lower rate established by us.

## SECTION 6. DIVIDENDS

### 6.1 Annual Dividends

Each year, we determine an amount to be paid to you. The share, if any, for this contract, will be paid as a dividend at the end of the contract year. We do not expect that any dividend will be paid for this contract until at least two years (2) from the certificate date.

### 6.2 Use of Dividends

You may choose in writing to receive any dividend which may be declared in one of these ways:

- a. **CASH** – Payment back to you by check.
- b. **PAID UP ADDITIONS** – To buy more insurance on the insured's life.
- c. **DEPOSIT ACCOUNT** – To be left with us to earn interest at the rate we set from time to time. The rate will not be less than one and one-half percent (1-1/2%)
- d. **APPLIED TO REDUCE PREMIUMS**. If after the dividends are applied toward your premium you have dividend monies remaining, the excess dividends will remain on deposit and earn interest until the next premium payment becomes due. If the dividend is not sufficient to cover the premium, you will be billed for the net premium due. To remain under this option, all future contract premiums must be paid on an annual or semi-annual basis.

Your choice may be made on the application for your contract, or in writing at a later date. If no choice is made, Option c. will be applied.

### 6.3 Lapse, Termination, and Expiry of Contract

In the event of lapse of this contract, we will advise you that we will apply any dividends held on deposit toward payment of the premium. If the dividends are not sufficient to pay the premium, the dividends will be sent to you.

In the event of termination of this contract, we will pay you any outstanding dividends.

In the event of expiry of this contract, we will pay you any outstanding dividends, unless you have previously selected another dividend option listed above.

## SECTION 7 CASH VALUES, REDUCED PAID UP INSURANCE AND EXTENDED TERM INSURANCE

### 7.1 Guaranteed Values

Guaranteed options are available when values are shown in the Table of Values. The following options shall also be available if you do not pay your premiums by the due date or during the sixty days (60) after the due date.

1. **Cash Surrender** - If you surrender this contract, we will pay you the Net Cash Value. The Net Cash Value is:
  - The Cash Value defined in the Table of Values  
PLUS
  - The amount of any dividends held on deposit  
PLUS
  - The Cash Value of any Paid-Up Additions  
MINUS
  - The amount of any indebtedness

If this contract has been in force for three full years, during the sixty (60) days after a due date this option is available even if option 2 or 3 below was automatically put in place.

If you surrender the contract within thirty (30) days of a contract anniversary date, the Net Cash Value will not be less than the Net Cash Value as of that contract anniversary date.

The Paid Up or Extended Term Insurance may be surrendered at any time for the Net single premium of the remaining benefit using the Basis of Values described in Section 7.2

We may defer the payment of the Net Cash Value for a period not to exceed six months after the request for surrender of the contract, and we will comply with any applicable law concerning the timing of our payment or interest on it.

**2. Reduced Paid Up Insurance** – This Contract may be converted into a paid-up contract providing a reduced amount of insurance commencing on the due date of the premium in default. The amount of insurance will be the amount that the Net Cash Value will purchase when applied as a net single premium at the attained age of the Insured. The paid-up insurance will be payable at the same time and under the same conditions as this contract. Benefits provided by any riders will end. This paid up insurance will be eligible for dividends.

**3. Extended Term Insurance** – If no other guaranteed option is elected, this contract will automatically become a paid-up term contract. This contract will provide Extended Term Insurance commencing on the due date of the premium in default. The Extended Term Insurance will be for the Face Amount of this contract plus any dividend accumulations or paid up additions, and less any indebtedness. This term insurance will be extended for the number of years and days that the Net Cash Value will purchase when applied as a net single premium at the then attained age of the Insured. At the end of this term period, this contract will terminate.

This contract will no longer be eligible for dividends and the contract loan provisions will no longer apply. Benefits provided by any rider will end.

## **7.2 Basis of Values**

Guaranteed values, present values, net single premiums, and Extended Term Insurance benefits in this contract are based on the Commissioner's 2001 Standard Ordinary Male and Female Ultimate Mortality Tables. Interest is at five percent (5%) per year.

All computations consider that the contract is issued on the basis of the Insured's sex and age at last birthday. They are also based on the assumption that death benefits are payable immediately upon death.

The commissioner's Reserve Valuation Method is used in the calculation of reserves.

We have filed a detailed statement of the method of computation with the insurance supervisory official of the state in which this contract is delivered. The cash surrender values and the paid-up forfeiture benefits available under this contract are equal to or greater than those required by the law of any state in which this contract is delivered.

## **7.3 Table of Guaranteed Values**

The guaranteed values applicable for the contract are shown in the Table of Values for the issue age, sex and premium class for the face amount shown on page 3.

Values shown apply at the end of the contract year. The values of any other time will be determined giving allowance for the part of the year for which the premiums are paid. Values at the end of the contract years not shown will be furnished upon request.

Any indebtedness on this contract will reduce the values shown.

**[TABLE OF GUARANTEED VALUES  
Male Non-Tobacco Age 35**

END OF POLICY YEAR	CASH VALUE	PAID-UP INSURANCE	EXTENDED TERM INSURANCE	
			YEARS	DAYS
1	\$ 0.00	\$ 0	0	0
2	0.00	0	0	0
3	410.00	2,500	3	40
4	1,283.00	7,400	8	43
5	2,194.00	12,000	12	21
6	3,140.00	16,500	14	360
7	4,122.00	20,700	17	41
8	5,139.00	24,800	18	279
9	6,191.00	28,600	19	362
10	7,277.00	32,300	20	334
11	8,399.00	35,800	21	239
12	9,557.00	39,100	22	95
13	10,760.00	42,300	22	270
14	12,012.00	45,300	23	36
15	13,314.00	48,300	23	122
16	14,663.00	51,100	23	177
17	16,057.00	53,700	23	205
18	17,493.00	56,300	23	209
19	18,968.00	58,700	23	191
20	20,478.00	61,000	23	153
Age				
65	37,420.00	78,400	20	145
85	74,538.00	94,700	11	138
100	89,098.00	98,100	6	244
121	100,000.00	100,000]		

**SECTION 8 LOANS**

**8.1 Loan**

You can get cash from us by taking a loan. If there is an existing loan, you can increase it. You may obtain a loan from us with this Contract as sole security if:

- a. You give Written Notice; and
- b. The loan does not increase indebtedness to more than the Cash Surrender Value plus the cash value of any paid up additions.

We have the right to defer making a cash loan for up to six months from the date the loan is requested, except when the request is made to pay premiums on any contract with us.

**8.2 Automatic Premium Loan**

A premium which remains unpaid at the end of a grace period will be paid with an automatic contract loan if:

- a. You ask us to do so in the application for your contract, or in writing while no premium is due and unpaid; and,
- b. Your contract has enough cash value to pay the premium.

You may elect or revoke the premium loan provision by written request.

**8.3 Loan Interest**

The loan interest rate charged will not exceed the greater of (1) and (2), where:

1. is the Interest Rate shown in the Contract Specifications plus 1% per annum; and
2. is the Moody's Corporate Bond Yield Average-Monthly Average Corporates for the calendar month ending two months before the beginning of the month in which your Contract Anniversary falls. If the maximum is at least one-half of one percent smaller than the rate we have set for the previous contract year, we will reduce the rate to a rate

no more than that maximum. If the maximum is at least one-half one percent greater than the rate we have set for the previous contract year, we will increase the rate to a rate no more than that maximum. Moody's Corporate Bond Yield Average-Monthly Average Corporates referred to above is pushed by Moody's Investors Service, Inc. In the event it is no longer published, we will use a similar average established by applicable regulation.

Interest will accrue daily on loans. Accrued interest may be paid at any time at the equivalent effective rate. In the event you do not pay the loan interest charged in any contract year, it will be borrowed against the contract and added to the contract indebtedness and bear interest at the same rate.

When a loan is made, we will inform you of the rate and if any rate increase is to be made within 40 days. We will mail a notice to you and any assignee recorded at the Home Office at least 30 days before we make any rate increase which will apply to an existing loan.

#### **8.4 Indebtedness**

Indebtedness consists of all unpaid loans and accrued interest. Indebtedness may be repaid at any time. Any indebtedness will be deducted from the contract proceeds.

If indebtedness equals or exceeds the cash value, the contract will terminate. We will mail notice to you at least 31 days before termination. We will also mail notice to any assignee on our records. You can prevent termination by making sufficient repayment of the loan.

### **SECTION 9 BENEFICIARY**

#### **9.1 Designated Beneficiary**

The beneficiary is the person or persons to whom the insurance proceeds are payable when the insured dies.

The beneficiary:

- a. will receive the proceeds when the insured dies;
- b. is named in the application for this contract; and
- c. may be changed by the owner. The change is subject to the terms shown in the Change of Beneficiary provision.

If not otherwise provided:

- a. The interest of any beneficiary who dies before the insured will pass to any other beneficiaries according to their interests.
- b. If no beneficiary survives the insured, the proceeds will be paid in one sum to the owner, if living. If the owner is not living, the proceeds will be paid to the owner's estate.

#### **9.2 Change of Beneficiary**

The owner may change the beneficiary designation:

- a. while the insured is alive; and
- b. if the prior designation does not prohibit such a change; and
- c. the consent of any irrevocable beneficiary is obtained.

A change will revoke any prior designation. No change is binding on us until it is recorded at our home office. Once recorded the change binds us as of the date you signed it. The change will not apply to any payment made by us before we recorded your request. We have the right to require that you send us this contract so we can record the change.

### **SECTION 10. PAYMENT OF INSURANCE PROCEEDS**

#### **10.1 Optional Payment Plans**

At the time of their commencement, any benefits provided under this contract will not be less than those provided by the application of the Cash Surrender Value to purchase a single premium immediate annuity contract at purchase rates offered by us at the time to the same class of annuitants.

If no optional payment plan is selected, any benefits provided by this contract will be paid in cash.

The optional payout plans available to the Beneficiary upon death of the Insured are:

**A. Interest Deposit Account** - The allocated proceeds will earn interest annually at rates that we determine from time to time, but never less than one and one-half percent (1.5%) The interest may be paid periodically or left to accumulate. The payee may withdraw all or part of the account at any time.

**B. Payments For a Guaranteed Period** – We will periodically pay the amount that is calculated so that the allocated proceeds plus interest are fully paid over a guaranteed period that may be selected. The guaranteed period must be at least five (5) years. We reserve the right to set a maximum limit. The payee may not withdraw any of the account at any time.

**C. Payments Based on a Single Life**

1. **Life Only** – We will periodically pay the amount that is calculated so that the allocated proceeds plus interest would be fully paid over the payee's life expectancy. We will pay that amount as long as the payee is alive. We will make no further payments after the payee's death. The payee may not withdraw any of the account at any time.

2. **Life or Certain Period** – We will periodically pay the amount that is calculated so that the allocated proceeds plus interest would be fully paid over a period based on the payee's life expectancy and the probability that the payee would not survive a certain period that may be selected. The certain period must be either ten (10) or twenty (20) years. If the payee dies during the certain period, we will pay the present value of the remaining certain-period payments to the payout plan beneficiary pursuant to his or her election of a lump sum or an eligible payout plan. To be eligible, the payout plan must pay out at least as rapidly as the plan in effect when the payee died. If the payout plan beneficiary does not make such an election, we will pay the annuity proceeds in a lump sum. If the payee survives beyond the selected period, we will continue making the periodic payments until the payee's death. The payee may not withdraw any of the account at any time.

**D. Joint and Survivor Lifetime Annuity Payments** – We will periodically pay the amount that is calculated so that the allocated proceeds plus interest would be fully paid over a period based on the life expectancies of two (2) payees. We will pay that amount as long as one or both payees are living. Neither beneficiary may withdraw any of the account at any time.

**E. Other Plans** – Other periodic plans may be arranged with us.

**10.2 Minimum Payment Guarantee**

1. The amount of the periodic payment in Section 11.1 under paragraphs B through E will be determined by a single interest rate that we will declare when the plan takes effect and which will be at least one and one-half percent (1.5%). Payments that depend on one or more lives will also be determined by a mortality table that we will declare when the plan takes effect and which will be at least as favorable to the beneficiary as the Annuity 2000 Mortality tables, split by sex.

2. Tables 1, 2 and 3 in Section 11.5 show the minimum guaranteed payments for each plan in Section 10.1 under paragraphs B, C and D respectively under certain stated assumptions.

**10.3 Who May Choose a Payment Plan**

A choice of payment plan for insurance proceeds may be made by you while the insured is still alive. If no selection is made, the beneficiary shall have the right to select the plan. All choices of payment plans will take effect when recorded by us. When a payment plan starts, we will issue a contract which will describe the terms of the plan. We may require that you send us this certificate. If the payee is not a natural person, the choice of an income plan will be subject to our approval.

**10.4 Frequency of Payments**

Monthly, quarterly, semiannual or annual payments may be selected.

**10.5 Payout Plan Guaranteed Payments**

The monthly amounts shown are for each \$1,000 applied. To change monthly payments to quarterly, semiannual or annual payments, multiply the monthly amount by 3.00; 6.02; or 12.08, respectively. The tables assume that no withdrawals are made, only the guaranteed interest of one and one-half percent (1.5%) is paid, and payments are made at the end of the payment mode selected. Tables 2 and 3 are based on the Annuity 2000 Mortality tables, split by sex.

**TABLE 1 PAYOUT PLAN B: PAYMENTS FOR A GUARANTEED PERIOD**

Years Selected	Monthly Amounts						
5	17.31	9	9.90	13	7.05	17	5.55
6	14.53	10	8.97	14	6.60	18	5.28
7	12.54	11	8.22	15	6.20	19	5.04
8	11.06	12	7.59	16	5.86	20	4.82

**TABLE 2 PAYOUT PLANS C: PAYMENTS FOR LIFE**

	No Certain Period				Certain Periods	
					10 Year	20 Year
Payee's Age	Male	Female	Male	Female	Male	Female
50	3.26	3.01	3.23	3.00	3.15	2.96
55	3.65	3.35	3.61	3.33	3.46	3.25
60	4.17	3.79	4.09	3.75	3.80	3.59
65	4.88	4.39	4.71	4.30	4.15	3.97
70	5.86	5.22	5.47	5.02	4.45	4.34

**TABLE 3 PAYOUT PLAN D: JOINT AND SURVIVOR LIFETIME ANNUITY PAYMENTS**

Male Age	Female Age				
	50	55	60	65	70
50	2.72	2.86	2.97	3.06	3.13
55	2.81	2.99	3.16	3.31	3.42
60	2.88	3.10	3.33	3.55	3.75
65	2.93	3.19	3.48	3.79	4.09
70	2.96	3.25	3.59	3.99	4.41

**WHOLE LIFE INSURANCE**

Insurance Payable at Death of Insured  
Premiums Payable for Stated Period  
Schedule of Benefits and Premiums in Section 1  
Participating



1100 West Wells Street  
Milwaukee Wisconsin 53233  
800-927-2547  
[[www.catholicknights.org](http://www.catholicknights.org)]

CATHOLIC KNIGHTS  
WAIVER OF PREMIUMS BENEFIT RIDER

This Rider shall become a part of the life Contract to which it is attached. The Rider provisions apply in lieu of any Contract provisions to the contrary. The effective date of this Rider is shown on the Specifications Page of the Contract.

**Benefit**

You will not have to pay premiums if the Insured becomes disabled. We will refund any premium paid during the period of Disability. If the premiums are being waived, all benefits included in the Contract shall continue in force. Any premium waived will not reduce any death benefit.

**Definition of Disability**

Disability means that the Insured is unable to perform the duties of his/her job due to sickness or accidental bodily injury. Duties mean the substantial and material duties. Disability must be for a continuous period of six months.

During the first 24 months, Disability means being unable to perform the duties of the Insured's regular job. After the first 24 months, it means being unable to perform the duties of any job for which he/she become reasonably qualified for by reason of education, training, or experience.

If the Insured was a student when Disability began, going to school is the Insured's regular job.

The total and permanent loss of sight of both eyes will be considered as Disability. So will the loss of the use of both hands, both feet, or one hand and one foot.

**Premium**

The premium for this Rider is shown on the Specifications Page. It remains level until the expiry date shown on the Specifications Page.

Before we approve a claim for waiver benefit, the payment of the premiums when due is required to avoid a lapse of insurance. If we approve the claim for the wavier benefit after the continuous period of six months, we will refund the premiums paid after the first of the benefit month on or following the date the insured's total disability began.

**Cash Values**

This Rider does not provide for any cash values or loan values.

**Risks Not Covered**

The Rider does not cover a disability which:

1. Began before the Contract Date; or
2. Began after the Contract anniversary on or next following the Insured's 65<sup>th</sup> birthday;  
or

3. Began after the grace period of an unpaid premium. If Disability begins during a grace period, payment of the overdue premium is required to avoid a lapse of coverage before we approve the claim for the waiver benefit.
4. Was caused or contributed to by any attempt at suicide, or intentionally self-inflicted injury, while sane or insane; or
5. Is a result of war or act of war, if the cause of disability is while the Insured is serving in the Military, Navy, or Air Force of any country, combination of countries, or international organizations. Disability is not covered provided it occurs while in such forces or within six months after termination of service in such forces.
6. Is caused by or contributed to by any condition disclosed in the application and explicitly excluded in a form attached to the Contract.

### **Proof of Disability**

Written notice and proof must be given to us:

1. While the Insured is alive and disabled; and
2. Within 12 months of any termination of this Rider.

As part of any proof, we may require, at our expense, medical examinations of the Insured by physicians we choose.

We may also require written proof of continued Disability once every 60 days. After two years of Disability, proof will not be required more than once a year.

If notice or proof is late, we will accept it if it is given as soon as reasonably possible. If not given as soon as reasonably possible, we will not waive any premium that was due more than one year before the date written notice or proof was given to us.

If proof is not given when required or if the Insured does not submit to a medical examination, all the premiums due after that time will be payable by you.

### **Recovery from Disability**

If and when the Insured recovers, all premiums becoming due thereafter are payable by you. The premium payment in effect at the start of the Disability will determine the next premium due date.

### **Exchange of the Contract**

If the Contract to which this Rider is attached is exchanged prior to disability, the new Contract will include this Rider.

### **Termination**

This Rider terminates on the first Contract anniversary beginning on or next following the Insured's 65<sup>th</sup> birthday. It also terminates upon termination of the Contract.

Nonpayment of a premium when due or within the grace period for that premium will terminate this Rider.

Upon written request this Rider may be terminated. We may require the return of the Contract for proper endorsement.

If the Contract is reinstated prior to the expiry date, this Rider will likewise be reinstated.

Signed at our Home Office in Milwaukee, Wisconsin on the certificate date.

*William R. O'Toole*

President

*Allan G. Joyce*

Secretary

SERFF Tracking Number: CAKN-126705325

State: Arkansas

Filing Company: Catholic Knights

State Tracking Number: 46121

Company Tracking Number: 17-710

TOI: L071 Individual Life - Whole

Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Whole Life

Project Name/Number: CNO-17 ss/17-710

## Supporting Document Schedules

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

Flesch Cert AR.pdf

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Application

**Comments:**

**Attachments:**

2010 LF App.pdf

2010 LF App2.pdf

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Reg 19 certification

**Comments:**

**Attachment:**

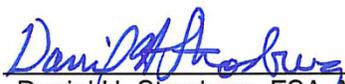
Reg 19 CERT AR signd.pdf

**STATE OF ARKANSAS  
READABILITY CERTIFICATION**

**COMPANY NAME:** Catholic Knights

This is to certify that the form referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
2010 WL AR	53.0
2010 WP WL	50.5



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Daniel H. Strasburg, FSA, MAAA  
Vice President and Chief Actuary  
June 28, 2010



Application for Membership and Insurance to:

[Catholic Knights]
1100 West Wells Street
Milwaukee, Wisconsin 53233
(800) 927-2547

[ ] New Business
[ ] Conversion from Certificate No: \_\_\_\_\_

[ ] New Member
[ ] Changes to Certificate No: \_\_\_\_\_

A. MEMBERSHIP

Proposed Primary Insured

[ ] Male [ ] Female SS/ITIN No \_\_\_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_
Name: \_\_\_\_\_
First Middle Initial Last
Address: \_\_\_\_\_
Street City State Zip
Home phone: \_\_\_\_\_ Work/cell phone: \_\_\_\_\_ Email: \_\_\_\_\_
Where can you be reached for additional information? \_\_\_\_\_
Best Days: M T W T H F Best times \_\_\_\_\_ [ ] a.m. [ ] p.m.
Are you a US Citizen, or do you have permanent residence status?
[ ] Yes - Proof of Identity \_\_\_\_\_
[ ] No - If not a U.S. citizen, provide 1-151 (green card) number \_\_\_\_\_ No. of years in US \_\_\_\_\_
Driver's License: \_\_\_\_\_ State \_\_\_\_\_
Previous Name/s: \_\_\_\_\_
Occupation: \_\_\_\_\_ Employer \_\_\_\_\_ Income \_\_\_\_\_
Is the Proposed Insured Catholic? [ ] Yes [ ] No Parish \_\_\_\_\_
If no, do you otherwise qualify for membership? Explain \_\_\_\_\_

Owner (Must complete section if Owner is not the Insured)

[ ] Individual Relationship to proposed insured \_\_\_\_\_
[ ] Male [ ] Female SS/ITIN No: \_\_\_\_\_ DOB \_\_\_\_\_
Name: \_\_\_\_\_
First Middle Initial Last
Address: \_\_\_\_\_
Street City State Zip
Home phone: \_\_\_\_\_ Work/cell phone: \_\_\_\_\_ Email: \_\_\_\_\_
[ ] Trust Contact person \_\_\_\_\_ Tax ID No. \_\_\_\_\_
Phone \_\_\_\_\_ Email \_\_\_\_\_

Successor Owner

[ ] Male [ ] Female SS/ITIN No \_\_\_\_\_ DOB: \_\_\_\_\_
Name: \_\_\_\_\_
First Middle Initial Last
Address: \_\_\_\_\_
Street City State Zip
Home phone: \_\_\_\_\_ Work/cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Payor (complete if Payor is other than insured or Owner)

Relationship to owner and insured \_\_\_\_\_
SS/ITIN No: \_\_\_\_\_ DOB \_\_\_\_\_
Name: \_\_\_\_\_
First Middle Initial Last
Address: \_\_\_\_\_
Street City State Zip
Home phone: \_\_\_\_\_ Work/cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

POLICY DATE POLICY NUMBER

**Additional Proposed Insured**

Male  Female SS/ITIN No \_\_\_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_ State of Birth \_\_\_\_  
 Name: \_\_\_\_\_  
                     First                      Middle Initial                      Last  
 Address: \_\_\_\_\_  
                     Street    City    State                      Zip  
 Home phone: \_\_\_\_\_ Work/cell phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Where can you be reached for additional information? \_\_\_\_\_  
 Best Days: M T W T H F                      Best times \_\_\_\_\_  a.m.  p.m.  
 Are you a US Citizen, or do you have permanent residence status?  
 Yes - Proof of Identity \_\_\_\_\_  
 No - If not a U.S. citizen, provide 1-151 (*green card*) number \_\_\_\_\_ No. of years in US \_\_\_\_  
 Driver's License: \_\_\_\_\_ State \_\_\_\_\_  
 Previous Name/s: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer \_\_\_\_\_ Income \_\_\_\_\_  
 Is the Proposed Insured Catholic?  Yes  No Parish \_\_\_\_\_  
 If no, do you otherwise qualify for membership? Explain \_\_\_\_\_

**Children's Information (List additional children in Remarks)**

Male  Female SS/ITIN No \_\_\_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_  
 Name: \_\_\_\_\_ HT \_\_\_\_ WT \_\_\_\_  
                     First                      Middle Initial                      Last  
 Male  Female SS/ITIN No \_\_\_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_  
 Name: \_\_\_\_\_ HT \_\_\_\_ WT \_\_\_\_  
                     First                      Middle Initial                      Last  
 Male  Female SS/ITIN No \_\_\_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_  
 Name: \_\_\_\_\_ HT \_\_\_\_ WT \_\_\_\_  
                     First                      Middle Initial                      Last  
 Are there any children on whom coverage is not being requested?  Yes  No  
 If yes; child's name \_\_\_\_\_ Reason \_\_\_\_\_

**Beneficiary (List additional beneficiaries in Remarks)**

**INDIVIDUAL**                       **ESTATE**                       **TRUST**                       **GIFT to PARISH or OTHER CHARITY**  
 Primary: Full Name                      Relationship                      Social Security/Tax ID No  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Contingent: Full Name                      Relationship                      Social Security/Tax ID No  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Parish/Charity Name \_\_\_\_\_ Amount or Percent \_\_\_\_\_  
 Custodian for minors: Name \_\_\_\_\_ DOB \_\_\_\_\_ SS/ITIN/TAX No \_\_\_\_\_  
 The share of any beneficiary who does not survive shall be paid in equal shares to the beneficiary's surviving children

**B. COVERAGE****Plan Of Insurance;** \_\_\_\_\_

Face Amount \$ \_\_\_\_\_  Single Premium \_\_\_\_\_  
 Amount remitted with this application in Exchange for the Society's receipt \$ \_\_\_\_\_  
 (See Receipt and Conditional Life Insurance Agreement)  
 Mode:  Annual                       Semi-Annual  Quarterly                       Monthly EFT \_\_\_\_\_ (*day*)  
 Dividend Option:                       Cash                       Paid Up Life Additions                       Interest                       Reduced Premium  
 Automatic Loan                       Yes                       No  
 (UL only) Option  #1 Level                       #2 Increasing  
 UL planned premium \$ \_\_\_\_\_  
 Layer/Additions to UL Amount \_\_\_\_\_ =

POLICY DATE	POLICY NUMBER
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**Riders**

- Accidental Death Benefit  Waiver of Premium
- Guaranteed Insurability Option  Paid Up Addition
- Term Rider (Primary Insured) \$ \_\_\_\_\_
- Term Rider (Additional Insured) \$ \_\_\_\_\_
- Children's Term Rider \$ \_\_\_\_\_

**Premium Class**

- Primary  Tobacco  Select Tobacco  Non-Tobacco  Select  Select Plus
- Additional Insured Primary  Tobacco  Select Tobacco  Non-Tobacco  Select  Select Plus

**We will issue the policy in the Premium Class for which the Proposed Insured qualifies**

**C. REPLACEMENT/SUITABILITY**

1. Does any proposed insured have any existing coverage and/or pending applications for individual life insurance or annuities with this or any other company? (other than group)  Yes  No
  2. Does any proposed insured intend to replace, discontinue or change any such coverage?  Yes  No
- If YES to 1 or 2 provide the following information, and complete and return any required replacement forms**

Insured Name	Policy No:	Amount	Company

**D. PRELIMINARY DECLARATION OF INSURABILITY**

- Primary**                      Height \_\_\_\_\_                      Weight \_\_\_\_\_
1. Has the Proposed Insured ever been told s/he had or been treated for diabetes, cancer, heart disease, alcoholism, drug abuse, or high blood pressure?  Yes  No
  2. Has the Proposed Insured ever had insurance or reinstatement denied, postponed, limited, or offered on a substandard basis?  Yes  No
  3. Has the Proposed Insured used tobacco in any form in the past 12 months?  Yes  No
- Additional Proposed Insured:** Height \_\_\_\_\_                      Weight \_\_\_\_\_
1. Has the Additional Insured ever been told s/he had or been treated for diabetes, cancer, heart disease, alcoholism, drug abuse, or high blood pressure?  Yes  No
  2. Has the Additional Insured ever had insurance or reinstatement denied, postponed, limited, or offered on a substandard basis?  Yes  No
  3. Has the Additional Insured used tobacco in any form in the past 12 months?  Yes  No

**E. REMARKS**

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**F. AUTHORIZATION TO OBTAIN and DISCLOSE INFORMATION**

I (we) have read all the questions and answers in the application. All responses are true and complete to the best of my (our) knowledge and belief. No coverage will be in effect until: a full application has been signed by the Proposed Insured; and a policy has been issued; and the full first premium has been received by the Society; and any amendments are signed. Any coverage will be subject to the terms and conditions of the policy.

I (we) have received the notification about the Federal Fair Credit Reporting act and the Medical Information Bureau.

I AUTHORIZE the following to release information about me to Catholic Knights or its reinsurers. Those authorized include a physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, a consumer reporting agency, and/or employers.

POLICY DATE	POLICY NUMBER
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**F. AUTHORIZATION TO OBTAIN and DISCLOSE INFORMATION (Continued)**

I UNDERSTAND that this information may include diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment, and other non-medical information (such as credit reports and employer reports) concerning me. I authorize all sources, except MIB, to give records or knowledge to any agency employed by Catholic Knights. I authorize them to collect and transmit such information I UNDERSTAND they will use the information obtained through this Authorization to determine eligibility for insurance. Any information obtained will not be released to any person or entity EXCEPT to reinsuring companies, or other persons or organization performing business or legal services with my application. The Society may release this information when lawfully required, or as I further authorize.

I KNOW that I, or my authorized representative, may request a copy of this Authorization. I AGREE that a photographic or faxed copy of this Authorization shall be as valid as the original. I ACKNOWLEDGE that I received the "Notice to Applicant" form. I AGREE this Authorization shall be valid for two years from the date shown below.

**G. AGREEMENT (check one)**

Catholic Knights conditional coverage receipt was given for this life insurance plan. I acknowledge that I have read the receipt provided and understand its terms, conditions and limitations. I understand that I will not receive any insurance coverage for my money unless a policy is issued as applied for.

No conditional coverage receipt was given for this insurance plan. I acknowledge that I have not paid nay premium for this insurance. I understand that this insurance is not in effect and that the first premium must be paid upon delivery of the policy.

I hereby apply for insurance in the amount on the plan and at the rate stated in this application. I agree that the entire contract consists of this application for life insurance and all supplemental application forms required for the contract or change applied for the policy, the statement of insurability, and medical examination statements, the Articles of Incorporation and By-Laws of the Society.

**IT IS AGREED:**

- 1) I have read the application and all statements in this application are to the best of my knowledge and belief true, complete and correctly recorded.
- 2) No Representative of the Society has the authority to waive any question contained in the application or to modify the application in any way.
- 3) No Representative is authorized to change or waive any terms of this agreement or to make any promises or representations other than those contained in this agreement.
- 4) No information acquired by any agent shall bind the Society unless set out in writing in this application.
- 5) Unless otherwise provided in a conditional receipt bearing the date of the application, no liability exists until a contract is delivered, accepted by the owner and the first payment made. This must occur during the lifetime and insurability of the applicant under this contract and the health of all persons to be insured remains as stated in the application.
- 6) The contract applied for shall take effect on the later of the date requested by the applicant, or the approval date of the application from the Society at the Home Office.
- 7) When you accept the contract issued on this application, you are approving and ratifying any corrections, additions, or changes made by the Society. We do not make changes in the plan of insurance or payment without your written consent.
- 8) Except as provided in the Conditional Temporary Life Insurance Agreement Receipt, issued if the first premium for the contract applied for is paid, no insurance will take effect unless and until
  - a. A contract of insurance is issued and delivered
  - b. The first full premium is paid during the life time of the person to be covered; and
  - c. The health of all persons to be insured remains as stated in this application.

**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 state law.**

Dated at \_\_\_\_\_ on \_\_\_\_\_  
City State Month Day Year

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Proposed Additional Insured

\_\_\_\_\_  
Signature of Parent/Guardian for Minor

\_\_\_\_\_  
Signature of Owner (if other than insured)

\_\_\_\_\_  
Signature of Agent Agent No. \_\_\_\_\_

Split Advisor No. \_\_\_\_\_ Percentage \_\_\_\_\_

POLICY DATE POLICY NUMBER



**PART II SUPPLEMENTARY**

Application for Membership and Insurance to:  
 [Catholic Knights]  
 1100 West Wells Street  
 Milwaukee, Wisconsin 53233  
 (800) 927-2547

Full Legal Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Policy Number \_\_\_\_\_

Interviewer \_\_\_\_\_

Date of Interview \_\_\_\_\_

**PROPOSED INSURED MUST COMPLETE ALL QUESTIONS. ALL "YES" ANSWERS MUST BE EXPLAINED AND REFERENCED IN REMARKS.**

	Yes	No
Has or does the person proposed for this insurance coverage:		
1) Ever engaged in or expect to engage within the next two years any of the following: a. Aviation activities as a pilot or crew member? b. Skin or Scuba Diving; organized motor vehicle or motor boat racing; mountain climbing; professional rodeo competition; skydiving; parachuting, hang-gliding?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
2) Are you or do you intend to become a member of the Armed Forces (including Reserves or National Guard)?	<input type="checkbox"/>	<input type="checkbox"/>
3) a. Drink alcoholic beverages? If yes, how much per week? _____ (one drink = 12 oz. beer, 4 oz. wine, or 1 oz. hard liquor) Amount _____ b. Now or ever used heroin, cocaine, marijuana, or illegal, restricted or controlled substance, except as prescribed by a physician? c. Ever had or been advised by a physician, practitioner, or court of law to have treatment for alcohol, drug, or substance abuse?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4) a. Had insurance or reinstatement refused, postponed, limited, offered, or quoted on a rated or substandard basis? b. Will this insurance replace or change any existing life insurance or annuity contract? c. Made within the past 5 years a claim for or received benefits compensation, or pension for any injury, sickness, disability, or impaired condition? d. In the past 5 years been unable to work, attend school, or perform normal activities of like age and gender, or been confined at home.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
5) Ever been cited for driving while intoxicated (DWI), or driving under the influence (DUI)? a. Ever been cited for any other driving violation in the past 3 years?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
6) Ever been convicted in a court of law for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
7) a. Have you traveled outside the United States within the past 2 years or intend to travel outside the United States within the next 2 years? b. Have you lived outside of the United States within the past 2 years or intend to live outside the United States within the next 2 years?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
8) 8) Do you now use or have you ever used tobacco or nicotine in any form? If yes, indicate the type of tobacco used: <input type="checkbox"/> cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigar <input type="checkbox"/> chewing tobacco <input type="checkbox"/> other If applicable, the date you stopped: _____	<input type="checkbox"/>	<input type="checkbox"/>
9) a. Have a history in parents, brothers or sisters of mental illness, diabetes, heart, kidney or liver disease, high blood pressure, stroke or cancer? If yes, name persons(s), relationship(s), ages(s), conditions (s), and age when disease began in remarks section. b. Give name, cause and age at death of father, mother, brother(s), sister(s) if deceased: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
10) Full name and complete address of personal physician; the date, reason last seen and diagnosis: _____ _____		
11) Have you declared bankruptcy in the last 7 years or had any suits, judgments or liens against you? If yes, discharged date: _____	<input type="checkbox"/>	<input type="checkbox"/>

**COMPLETION OF QUESTIONS 12-19 IS REQUIRED IN ALL CASES. ANY "YES" ANSWERS MUST BE FULLY EXPLAINED AND REFERENCED IN REMARKS.**

AIDS TEST RESULTS OBTAINED AT AN ANONYMOUS COUNSELING AND TESTING SITE DESIGNATED BY THE STATE EPIDEMIOLOGIST OR AT A SIMILAR FACILITY IN ANOTHER JURISDICTION OR HOME TESTING ARE CONFIDENTIAL AND NEED NOT BE DISCLOSED. NONE OF THESE APPLICATION QUESTIONS SHOULD BE INTERPRETED AS ASKING ABOUT AIDS, UNLESS THE QUESTION SPECIFICALLY MENTIONS AIDS.

Has or does the person proposed for insurance coverage:	Yes	No
12) Ever been diagnosed or treated by a member of the medical profession for a disorder, disease or persistent discomfort of the following systems:		
a. Respiratory (lungs, bronchi, trachea, etc.) such as, but not limited to, TB, asthma, emphysema, bronchitis, shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
b. Circulatory (heart, blood, arteries, veins, etc.) such as, but not limited to, high blood pressure, heart attack, chest pains, murmur?	<input type="checkbox"/>	<input type="checkbox"/>
c. Digestive (Throat, esophagus, stomach, intestine, liver, gall bladder, etc.) such as, but not limited to, ulcer, colitis, cirrhosis, hemorrhoids, bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
d. Nervous (brain, nerves, etc.) such as, but not limited to, paralysis, stroke, fainting, dizziness, epilepsy, convulsions, recurring headaches?	<input type="checkbox"/>	<input type="checkbox"/>
e. Musculo-skeletal (muscles, bones, joints, spine, etc.) such as, but not limited to, neck/back problems, fracture, arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genito-urinary (kidney, bladder, reproductive organs, etc.) such as, but not limited to, kidney stones, infection, bleeding, male or female disorders?	<input type="checkbox"/>	<input type="checkbox"/>
g. Glandular (thyroid, pancreas, adrenal, lymph glands, etc.) such as, but not limited to, abnormal growth or function, including diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
13) Been diagnosed or treated by a member of the medical profession for:		
a. impaired sight, or eye disorder	<input type="checkbox"/>	<input type="checkbox"/>
b. impaired hearing, or ear disorder	<input type="checkbox"/>	<input type="checkbox"/>
c. hernia	<input type="checkbox"/>	<input type="checkbox"/>
d. skin disease	<input type="checkbox"/>	<input type="checkbox"/>
e. any sexually transmitted disorders or diseases	<input type="checkbox"/>	<input type="checkbox"/>
14) Been diagnosed or treated by a member of the medical profession for any mental, nervous, psychological, or emotional condition or disorder, such as, but not limited to, anxiety, depression, or nervous breakdown?	<input type="checkbox"/>	<input type="checkbox"/>
15) Now have or ever been diagnosed or treated for cancer, tumor, cyst, or growth?	<input type="checkbox"/>	<input type="checkbox"/>
16) Gained or lost more than 10 pounds in the past year? Amount: _____ Cause: _____	<input type="checkbox"/>	<input type="checkbox"/>
17) Within the past 5 years: (Refer to disclaimer concerning AIDS test results at top of page)		
a. Had any other impairment, sickness, injury, surgery not described above or any diagnostic test such as x-ray, EKG, lab tests?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had a physical examination? If yes, list the reason for and results below.	<input type="checkbox"/>	<input type="checkbox"/>
c. Been advised to have or do the following which was not completed 1) any diagnostic test; 2) surgery; 3) hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>
d. Been on, or now on, prescribed diet or medication? List description of medication or diet, date prescribed and name and address of prescriber in remarks	<input type="checkbox"/>	<input type="checkbox"/>
e. Currently take any herbs, vitamins, mineral supplements or other non-prescription remedies? List description of non-prescribed medications in remarks.	<input type="checkbox"/>	<input type="checkbox"/>
18) Been diagnosed or treated by a member of the medical profession the past 10 years for complications of pregnancy (such as C-section) or now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
19) a. Been treated or diagnosed by a member of the medical profession as having any disorder of the blood or immune system, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Ever been treated by a member of the medical profession as having the AIDS (TTLV-III) Virus or tested positive to FDA licensed blood tests?	<input type="checkbox"/>	<input type="checkbox"/>



**STATE OF ARKANSAS  
CERTIFICATION OF COMPLIANCE**

**Company Name:** Catholic Knights

**Form Titles:**

**Form Numbers:**

WHOLE LIFE INSURANCE CONTRACT  
WAIVER OF PREMIUMS BENEFIT RIDER

2010 WL  
2010 WP WL

I hereby certify that to the best of my knowledge and belief, the above forms and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

  
\_\_\_\_\_  
Daniel H. Strasburg, FSA, MAAA  
Vice President and Chief Actuary  
July 1, 2010