

**State:** Arkansas **Filing Company:** Degree of Honor Protective Association  
**TOI/Sub-TOI:** L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life  
**Product Name:** DOH APP INSURANCE-13  
**Project Name/Number:** DOH APP INSURANCE-13/

## Filing at a Glance

Company: Degree of Honor Protective Association  
Product Name: DOH APP INSURANCE-13  
State: Arkansas  
TOI: L09I Individual Life - Flexible Premium Adjustable Life  
Sub-TOI: L09I.001 Single Life  
Filing Type: Form  
Date Submitted: 01/03/2013  
SERFF Tr Num: GBAC-128821941  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num:  
  
Implementation: 01/03/2013  
Date Requested:  
Author(s): Mary Gardner  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/16/2013  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

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## General Information

Project Name: DOH APP INSURANCE-13 Status of Filing in Domicile: Pending  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Individual Market Type:  
 Overall Rate Impact: Filing Status Changed: 01/16/2013  
 State Status Changed: 01/16/2013  
 Deemer Date: Created By: Mary Gardner  
 Submitted By: Mary Gardner Corresponding Filing Tracking Number:

### Filing Description:

RE: DEGREE OF HONOR PROTECTIVE ASSOCIATION - NAIC #57088  
 APP INSURANCE-13F -- Application for Membership and Life Insurance

On behalf of Degree of Honor Protective Association, a fraternal benefit society incorporated under laws of the State of Minnesota, we are submitting the above-referenced individual life application.

APP INSURANCE-13F will replace application APP INSURANCE-09 approved 4/7/2009; SERFF #GBAC-126094152. The following are the basic changes made to the replaced application:

- Changes made to the Acknowledgement section, #1 for the MIB.
- Moved the smoker question from the medical question list to Section Q. Information for Proposed Insured(s).
- Changed the Electronic Funds Transfer section to allow initial premium to be drawn direct from the bank account.
- Added NAIC compliant replacement regulation wording direct into the application.
- Cosmetic changes to the spacing.

APP INSURANCE-13F will be used with the following insurance forms:

UL NLF-07 - Flexible Premium Adjustable Death Benefit Life Insurance approved 3/6/2007  
 ULIVZF(AR) - Flexible Premium Adjustable Death Benefit Life Insurance approved 12/4/2008; SERFF #GBAC-125915761

## Company and Contact

### Filing Contact Information

Mary Gardner, mgardner@lifebase.com  
 100 First Avenue N.E. 319-896-5970 [Phone]  
 Suite 117 319-896-5979 [FAX]  
 Cedar Rapids, IA 52401

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**Filing Company Information**

(This filing was made by a third party - griffithballardandco)

Degree of Honor Protective Association	CoCode: 57088	State of Domicile: Minnesota
287 W Lafayette Frontage Road	Group Code:	Company Type: Fraternal
Suite 200	Group Name:	State ID Number:
St. Paul, MN 55107-3464	FEIN Number: 41-0216310	
(800) 947-5812 ext. [Phone]		

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$125.00  
 Retaliatory? Yes  
 Fee Explanation: \$125.00 per form (Minnesota state of domicile)  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Degree of Honor Protective Association	\$125.00	01/03/2013	66204877

SERFF Tracking #:

GBAC-128821941

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/16/2013	01/16/2013

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	01/09/2013	01/09/2013

#### Response Letters

Responded By	Created On	Date Submitted
Mary Gardner	01/15/2013	01/15/2013

**SERFF Tracking #:**

GBAC-128821941

**State Tracking #:****Company Tracking #:****State:**

Arkansas

**Filing Company:**

Degree of Honor Protective Association

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DOH APP INSURANCE-13/

## Disposition

Disposition Date: 01/16/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Third Party Authorization Letter		No
Form (revised)	Application for Membership and Life Insurance		No
Form	Application for Membership and Life Insurance	Replaced	No

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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/09/2013
Submitted Date	01/09/2013
Respond By Date	02/11/2013

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Dear Mary Gardner,

**Introduction:**

*This will acknowledge receipt of the captioned filing.*

**Objection 1**

*Comments: We did not find an Arkansas Fraud Statement in the application as required by Ark. Code Ann. 23-66-503 and Bulletin 7-97.*

**Conclusion:**

*A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.*

*Please feel free to contact me if you have questions.*

*Sincerely,  
Linda Bird*

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 01/15/2013  
 Submitted Date 01/15/2013

Dear Linda Bird,

### Introduction:

### Response 1

#### Comments:

The Arkansas Fraud Warning has been added as the last paragraph of the Acknowledgement section (page 7). The application now contains an (AR) extension making the form state-specific.

### Related Objection 1

Comments: We did not find an Arkansas Fraud Statement in the application as required by Ark. Code Ann. 23-66-503 and Bulletin 7-97.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Application for Membership and Life Insurance	APP INSURANCE-13F(AR)	AEF	Initial		47.300	APP Insurance-13FAR.pdf	Date Submitted: 01/15/2013 By: Mary Gardner
<i>Previous Version</i>								
1	Application for Membership and Life Insurance	APP INSURANCE-13F	AEF	Initial		47.300	Generic Foundation John Doe.pdf	Date Submitted: 01/03/2013 By: Mary Gardner

No Rate/Rule Schedule items changed.

**SERFF Tracking #:**

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**Company Tracking #:**

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**Conclusion:**

Sincerely,

Mary Gardner

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## Form Schedule

Lead Form Number: APP INSURANCE-13

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Membership and Life Insurance	APP INSURANCE-13F(AR)	AEF	Initial		47.300	APP Insurance-13FAR.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages



# Degree of Honor Protective Association

287 W. Lafayette Frontage Road, Suite 200, Saint Paul, Minnesota, 55107-2464

1-800-947-5812 • (651)228-7600 • Fax: (651)224-7446

www.degreeofhonor.org

## Application for Membership and Life Insurance

**PLEASE PRINT WITH BLACK INK (medium point)**

**Identification Verification for any Proposed Insured and Owner.** The identification must be an unexpired government-issued identification card or document that includes a **photograph** and one or more of the following: driver's license number, taxpayer identification number, passport number and country of issuance, permanent resident identification number, or number and country of issuance of any other government-issued document evidencing nationality or residence.

**A. PROPOSED INSURED** *Please print* **Mail policy to**  **Agent**  **Owner**  **Other** \_\_\_\_\_

1. \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Name Middle Name Last Name

\_\_\_\_\_  
Street Address - RFD - Box Number

\_\_\_\_\_  
City State Zip Code

2. Social Security Number \_\_\_\_\_ 3. U.S. State or Country of Birth \_\_\_\_\_ 4. Age \_\_\_\_\_

5. Sex  Male  Female 6. Marital Status \_\_\_\_\_ 7. Former Last Name \_\_\_\_\_

8. E-mail address \_\_\_\_\_ 9. Driver's License # \_\_\_\_\_

10. Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_

Best time to call: \_\_\_\_\_

11. Citizenship:  U.S.  Other \_\_\_\_\_ Date of arrival in U.S. \_\_\_\_\_

U.S. Permanent Resident card? (green card)  Yes  No If no, list Visa type: \_\_\_\_\_  
letter, number & expiration date

12. Employer Name and address: \_\_\_\_\_

Duration(yrs): \_\_\_\_\_ Occupation/Duties: \_\_\_\_\_

13. Individual Income \$ \_\_\_\_\_ Net Worth \$ \_\_\_\_\_ Household Income \$ \_\_\_\_\_

14. Type of ID(s) \_\_\_\_\_ ID #(s) \_\_\_\_\_

**B. PROPOSED SPOUSE RIDER INSURED** *If being applied for:*

1. \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Name Middle Name Last Name

\_\_\_\_\_  
Address if different than above

2. Social Security Number \_\_\_\_\_ 3. U.S. State or Country of Birth \_\_\_\_\_ 4. Age \_\_\_\_\_

5. Sex  Male  Female 6. Former Last Name \_\_\_\_\_

7. E-mail address \_\_\_\_\_ 8. Driver's License # \_\_\_\_\_

9. Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_

10. Citizenship:  U.S.  Other \_\_\_\_\_ Date of arrival in U.S. \_\_\_\_\_

U.S. Permanent Resident card? (green card)  Yes  No If no, list Visa type: \_\_\_\_\_  
letter, number & expiration date

11. Employer Name and address: \_\_\_\_\_

Duration(yrs): \_\_\_\_\_ Occupation/Duties: \_\_\_\_\_

12. Individual Income \$ \_\_\_\_\_

13. Type of ID(s) \_\_\_\_\_ ID #(s) \_\_\_\_\_

**C. OWNERSHIP** (Required if Proposed Insured is Under Age 18) Must comply with Fraternal Code

Owner (if other than Proposed Insured)

\_\_\_\_\_  
First Name Middle Name Last Name  
 \_\_\_\_\_  
Street Address - RFD - Box Number City State Zip Code  
 \_\_\_\_\_  
Relationship to Proposed Insured Home Telephone # E-mail Address Social Security # Date of Birth  
 Type of ID(s) \_\_\_\_\_ ID #(s) \_\_\_\_\_

**D. CONTINGENT OWNER** (Optional) Must comply with Fraternal Code

Owner

\_\_\_\_\_  
First Name Middle Name Last Name  
 \_\_\_\_\_  
Street Address - RFD - Box Number City State Zip Code  
 \_\_\_\_\_  
Relationship to Proposed Insured Home Telephone # E-mail Address Social Security # Date of Birth  
 Type of ID(s) \_\_\_\_\_ ID #(s) \_\_\_\_\_

**E. PRIMARY INSURED BENEFICIARY DESIGNATION** *If more space is needed, use a separate paper.*

*Must comply with Fraternal Code.*

<b>Primary Beneficiary(ies)</b>	<b>SSN</b>	<b>%</b>	<b>Date of Birth</b>	<b>Relationship to Proposed Insured</b>
_____				
_____				
_____				
_____				

<b>Contingent Beneficiary(ies)</b>	<b>SSN</b>	<b>%</b>	<b>Date of Birth</b>	<b>Relationship to Proposed Insured</b>
_____				
_____				
_____				
_____				

If there is no surviving Beneficiary designated, the proceeds shall be paid to the Owner or the Owner's estate. Should the Owner or the Owner's estate fail to claim the funds within three years of the Insured's death, the funds shall be paid to the Degree of Honor Foundation.

**Beneficiary Designation if Spouse and/or Children's Riders are applied for:** The Beneficiary Designation on the Spouse and/or Children's Rider shall be the Primary Insured if living; otherwise the estate of the person insured by the Rider. The above shall apply unless otherwise indicated by a Beneficiary Designation form.

**F. SPECIAL REQUESTS** *For example: special issue date.* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**M. PROPOSED CHILD INSURED RIDER INFORMATION (if applied for)**

1. Name(s) of children to be covered by rider (must be under the age of 18 and unmarried)

Physical/Mental  
Abnormalities at Birth?  
(If yes, explain below)

Name (First, Middle, Last)	ID Number	Sex	Birthdate	Height	Weight

- Yes  No

2. Has any child listed above:

a. Had a weight change during the last year? .....  Yes  No

b. Received treatment for any disease, physical or mental condition, including ADD/ADHD in the past five years?.....  Yes  No

If yes to 1., 2a. or 2b. above, explain here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Are there any children under the age of 18 and unmarried not listed above?  Yes  No

If yes, List Name \_\_\_\_\_ Birthdate: \_\_\_\_\_

Reason for Exclusion: \_\_\_\_\_

4. Please list doctor's name(s), address(es) and phone number(s)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- N. WITHIN THE PAST 10 YEARS, HAS ANY PROPOSED INSURED HAD (including Spouse if Rider applied for. List details on page 6):**
- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. A disorder of the blood, heart, or circulatory system; chest pain, heart murmur, heart attack, rheumatic fever, irregular heart beat, high blood pressure, PVD (peripheral vascular disease), varicose veins, stroke, memory loss, dementia, aneurysm, anemia or any other disorder of the heart, blood vessels or circulatory system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Cancer, tumor, cyst, growth, or enlargement of the lymph glands?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. A disorder of the respiratory system; asthma, bronchitis, COPD, emphysema, tuberculosis, sleep apnea, shortness of breath or other lung disorders?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. A disorder of the digestive system; ulcer, colitis, rectal bleeding, diarrhea, hepatitis or other disorders of the stomach, esophagus, intestines, liver or gallbladder?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Diabetes, thyroid, adrenal, pituitary or other glandular disorder?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Albumin, blood, sugar or pus in the urine; any disorder of the kidney or bladder?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Epilepsy, convulsions, loss of consciousness, dizziness, paralysis, headaches, depression, anxiety, mental, emotional or nervous disorder, mental retardation or cerebral palsy?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. A disorder of the muscles, skin, or bone; arthritis, gout, connective tissue disorder or disorders of the back, joints, or extremities?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. A disorder of the reproductive system including prostate, testes, breast(s), ovaries or uterus, sexually transmitted disease, HPV, or current pregnancy?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. A disorder of the eyes, ears, nose, throat, or mouth?(other than glasses or contacts).....   | <input type="checkbox"/> | <input type="checkbox"/> |
- O. WITHIN THE PAST 5 YEARS HAS ANY PROPOSED INSURED (including Spouse if Rider if applied for. List details on page 6):**
- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 11. Had a medical checkup, sought or received medical advice or been advised to restrict normal activities because of illness or injury (including x-rays, ECGs, other tests or medication)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Been treated or evaluated at a hospital, clinic or other facility by a medical professional or been advised by a medical professional to have any test or surgery not yet completed?.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Consulted a hospital, clinic, psychiatrist, psychologist, or counselor for any reason?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Been refused a motor vehicle driver's license, had a license suspended, a moving traffic violation, or been cited for a DUI/DWI? (If "yes", give date, type of violation, and state).....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Used marijuana, cocaine, heroin, amphetamines or any other controlled or prohibited substances?.....<br>If Yes, give date last used: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Been treated for, received counseling, or been advised to seek counseling by a medical professional because of alcohol or drug usage?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
- P. HAS ANY PROPOSED INSURED (including Spouse if Rider applied for. List details on page 6):**
- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 17. Ever been diagnosed by a member of the medical profession or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an AIDS-related condition; or tested positive for the Human Immunodeficiency Virus (HIV)?.... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Received any medical advice, treatment, or surgery or presently have a physical impairment or illness not already listed?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Ever had a life or health insurance application declined, postponed, rated, modified or withdrawn? (If "yes", give name of company(ies), date, and reason).....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Within the past two years flown as a pilot, co-pilot, student pilot, or crew member?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Within the past two years participated in any of the following: scuba diving, skydiving, ultra-light flying, hang-gliding, or auto, boat, motorcycle or snowmobile racing?.....  | <input type="checkbox"/> | <input type="checkbox"/> |



**ACKNOWLEDGEMENT**

**I understand and agree that:**

1. I have read and received the Notice of Insurance Information Practices and the MIB, Inc. Pre-Notice. I authorize Degree of Honor Protective Association, or its reinsurers, to make a brief report of my personal health information to MIB.
2. I have read the previous statements and answers and to the best of my knowledge they are true and complete.
3. This application shall become part of the insurance contract together with our Articles of Incorporation and Bylaws, as amended from time to time.
4. No change in this application shall be made without my written consent.
5. No agent of Degree of Honor Protective Association is authorized to make or alter any contract or waive any Degree of Honor Protective Association rights or requirements.
6. No insurance shall take effect (unless otherwise provided in a completed Conditional Receipt) until:
  - a) the Policy is delivered and you accept it;
  - b) the first full premium is paid by check, money order or cashiers check made payable only to Degree of Honor Protective Association during the lifetime of the Insured; and
  - c) the insurability of the Proposed Insured remains as described in this application and all representations are true and correct.

Signed at \_\_\_\_\_, on \_\_\_\_\_  
City, State Date

\_\_\_\_\_  
Signature of Proposed Insured, age 15 or older (*primary Insured only*)

\_\_\_\_\_  
Signature of Spouse if Spouse Rider Applied For

\_\_\_\_\_  
Signature of Parent/Guardian, if under age 18

\_\_\_\_\_  
Authorized Agent

\_\_\_\_\_  
Signature of Owner if different than Proposed Insured

**ARKANSAS Fraud Warning:** 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.

**ILLUSTRATION CERTIFICATION**

**I have received an illustration with this application.**    Yes    No (If "no", complete acknowledgement below)

**Owner Acknowledgement**

I did not receive an illustration at the time I applied for my Degree of Honor Protective Association life insurance policy. I understand that an illustration conforming to the policy issued shall be provided no later than at the time of policy delivery.

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

**Authorized Agent Acknowledgement**

I certify that I did not present an illustration to the above-named Owner at the time of application.

Signature of Authorized Agent \_\_\_\_\_ Date \_\_\_\_\_

**LODGE/SERVICE CLUB MEMBERSHIP** Must be signed. Not applicable for Proposed Insureds age 17 or less.

Is(Are) Proposed Insured(s) now a member of the Association?  Yes Lodge/Service Club # \_\_\_\_\_ State \_\_\_\_\_  
 No (If "no", complete membership application below)

**APPLICATION FOR MEMBERSHIP TO DEGREE OF HONOR PROTECTIVE ASSOCIATION**

I **hereby apply** for membership in the Association and its local Lodge/Service Club # \_\_\_\_\_ State of \_\_\_\_\_  
I **understand** that unless I select a specific Lodge/Service Club, the Association will select the Lodge/Service Club to which I will be assigned membership.

I **agree** if accepted, to abide by the Articles of Incorporation and Bylaws of the Association and the Bylaws of said Lodge/Service Club, all as the same now exist or are hereafter amended.

I **hereby affirm** my belief in: Christian beliefs and values and demonstration of high moral character. The protection and support of family members and their dependents through fraternal insurance products. Promotion of the family unit and the seeking of ways to strengthen it. Assistance to members, their dependents and others in times of adversity. The desire to help others in need through community service and adherence to the principals of volunteerism. Maintenance of a representative form of government by providing members with the opportunity to become involved in structured events, club meetings and programs. Respect for and allegiance to the United States of America and its flag by promoting patriotism. Adherence to the Golden Rule "Do unto others as you would have them do unto you."

Signature of Proposed Member \_\_\_\_\_ Date \_\_\_\_\_

Signature of Proposed Member \_\_\_\_\_ Date \_\_\_\_\_

**ELECTRONIC FUNDS TRANSFER** I hereby authorize Degree of Honor Protective Association to initiate automatic premium payments to be charged to my account shown below and the Financial Institution named below to charge these premiums to such account. **Name of Financial Institution** \_\_\_\_\_

**Routing #** \_\_\_\_\_ **Account #** \_\_\_\_\_

**EFT WITHDRAWAL ACCOUNT**  Checking Account\*  Savings Account\*\*

\* If choosing EFT from **Checking Account**, attach a voided check for account and transit numbers.

\*\* If choosing EFT from **Savings Account**, attach a voided withdrawal slip with the preprinted account and transit numbers.

Draft my account for the first premium **ONLY** (initial premium may be drafted upon receipt of this application).

Draft my account for ongoing monthly premium payments **ONLY**.

Draft my account for **BOTH** first premium and ongoing monthly premium payments.

**COMPLETE FOR ONGOING PREMIUM PAYMENTS:**

**EFT WITHDRAWAL DATE BUSINESS DAY OF THE MONTH**  1st Day  8th Day  16th Day  23rd Day

**NOTICE TO POLICYHOLDERS:** This authority is to remain in full force and effect until the Financial Institution has received written notification from you of its termination in such time and in such manner as to afford the Financial Institution a reasonable opportunity to act on it. The Policyholder has the right to stop payment of a premium by notification to the Financial Institution prior to charging the account. After the account has been charged, a customer has the right to have the amount of an erroneous payment immediately credited to his(her) account by the Financial Institution up to 15 days following notification.

No premium payment shall be deemed to have been paid until Degree of Honor receives actual payment in its office, and the account, check or draft has been honored. Degree of Honor shall incur no liability as a result of the dishonor of any account debit, check or draft made under this authorization.

Name(s) (Please print) \_\_\_\_\_

Signature \_\_\_\_\_ 2nd Signature if Joint Account \_\_\_\_\_

**AGENT'S CONFIDENTIAL REPORT**

- 1. Did you personally see the Proposed Insured and ask each question?  Yes  No
- 2. Did the Proposed Insured contact you for this insurance?  Yes  No
- 3. Purpose for insurance?  Estate liquidity (estate taxes, clearance costs)  Business insurance (Give details. Must comply with Fraternal Code.)  Family income (survivor, retirement, etc)  Other personal needs (personal loan)  Other \_\_\_\_\_
- 4. How well do you know the Proposed Insured?  Very well  Casually  Just met  Relative  
If a relative, please explain relationship; \_\_\_\_\_
- 5. Are any other family members who are not on this application applying for insurance at this time?  Yes  No

Name(s) & Date	Relationship to Proposed Insured	Company	Plan/Amount

6. Indicate type of arrangements made:
- |                       | Nonmedical               | Basic Paramed            | H.O. Urine specimen      | Blood chemistry profile  | ECG                      | Other (explain below)    |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Proposed Insured      | <input type="checkbox"/> |
| Proposed Spouse Rider | <input type="checkbox"/> |

Other (indicate) \_\_\_\_\_

Name of paramedical facility or medical doctor being used \_\_\_\_\_  
Scheduled date of completion \_\_\_\_\_ Telephone # \_\_\_\_\_

- 7. Was the premium paid with this application?  Yes  No
- 8. Who paid the premium?  Owner  Proposed Insured  Other (explain below)
- 9. Additional information and explanations: \_\_\_\_\_

**SALES VERIFICATION**

This must be completed if applicant answered yes to any question listed on page 3 under the Replacement Information section.

I hereby verify the following in connection with this application for life insurance applied for that only the following Degree of Honor Protective Association approved preprinted sales materials were used:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

and that copies of all individualized sales materials including but not limited to, sales illustrations and financial needs analyses related to the specific policy or contract purchased are herewith enclosed with this application.

Agent Signature: \_\_\_\_\_ Date \_\_\_\_\_

**To the best of my knowledge and belief:**

1. I have asked all questions and recorded all answers as they were given to me by the Proposed Insured and/or Owner.
2. I know nothing about Proposed Insured's health, habits, avocations or life style affecting insurability which has not been stated in this application.
3. The Proposed Insured  **does**  **does not** have existing life insurance policies or annuity contracts.
4. The insurance applied for on this application  **is**  **is not** intended to replace or change any life insurance or annuity with this or any other organization, except as indicated. Section I must be completed.
5. The Notice of Insurance Information Practices and MIB, Inc. Pre-Notice and disclosure or outline(s) of coverage, if required, were left with the Proposed Insured and Owner.
6. I have explained the anti-money laundering/terrorist financing information collecting requirements to the Owner and Proposed Insured.
7. I  **have seen**  **have not seen** the Owner's photo ID and verified such identity.  
 I  **have seen**  **have not seen** the Proposed Insured's photo ID (as applicable) and verified such identity(ies).

DATED \_\_\_\_\_ SIGNED \_\_\_\_\_  
Authorized Agent

**AGENT PERSISTENCY NUMBER IS REQUIRED. PLEASE FULLY COMPLETE THIS SECTION.**

Persistency Number	Persistency Number
Print Agent's Name	Print Agent's Name
Agent's Signature	Agent's Signature
Agent's E-mail Address	Agent's Telephone Number
Agent's Telephone Number	Agent's E-mail Address
Percent (%)	Percent (%)

**CONDITIONAL RECEIPT**

Detach and deliver to applicant only if first premium is received.

- A. **WHEN INSURANCE IS EFFECTIVE.** It is mutually agreed that the insurance applied for will take effect prior to delivery of a policy as of the latest of the date hereof or the date of any required medical examination only if: (1) the application is fully and truthfully completed; (2) all medical examinations required by our published underwriting rules have been completed; (3) the Proposed Insured(s) is(are) eligible as of the Policy Date for the plan and amount of insurance applied for; (4) the Proposed Insured(s) is(are) approved as an insurable risk at standard rates under Association rules after receipt of required information; and (5) the required first full premium is paid by check, money order or cashiers check made payable to Degree of Honor Protective Association.
- B. **WHEN RECEIPT IS VOID.** This receipt shall be void and no insurance shall be in force hereunder if: (1) any of the required conditions in A above are not fulfilled; or (2) if any plan or amount applied for is declined or is not approved for issuance within 60 days of the date of the application; or (3) if a check in payment of premium is not honored on first presentation; or (4) if death occurs as a result of suicide or attempted suicide.

NO AGENT OR REPRESENTATIVE OF THE ASSOCIATION IS AUTHORIZED TO WAIVE ANY OF THE FOREGOING CONDITIONS

Received from \_\_\_\_\_ the sum of \_\_\_\_\_ as first premium for application  
Please print

Dated \_\_\_\_\_ relating to \_\_\_\_\_  
Proposed Insured(s)

subject to the foregoing terms and conditions.

Degree of Honor Protective Association  
287 W. Lafayette Frontage Road, Suite 200  
Saint Paul, Minnesota 55107-3464  
Telephone: 651.228.7600, 800.947.5812  
degreeofhonor.org

\_\_\_\_\_  
Authorized Agent



**NOTICE OF INSURANCE INFORMATION PRACTICES and MIB, INC. PRE-NOTICE**  
**Always detach and give to the Proposed Insured or Parent or Guardian**

Degree of Honor Protective Association appreciates your application and the confidence you have shown in us. Information regarding insurability is necessary to equitably evaluate your application. All information will be treated as confidential. Sources for this information include statements made on the application or possibly in a telephone interview from the Home Office, examination results, medical studies, and reports we receive from doctors, practitioners, medical facilities, the MIB, Inc., or from investigative consumer reports.

Degree of Honor and its reinsurers may make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734; telephone number 866-692-6901 (TTY 866-346-3642). Degree of Honor, or its reinsurers, may also release information from its file to other insurance companies to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

In addition, we may get an investigative report from a consumer reporting agency. This report may include personal interviews with your neighbors, friends or other acquaintances for information as to your general reputation, personal characteristics and mode of living. No information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance. Upon written request, you will be informed if such a report was obtained and, if so, the name and address of the consumer reporting agency to whom such a request was made. You may contact that agency and ask for a copy of this report.

Upon request, Degree of Honor will furnish details on how to obtain and correct personal information in its file.

*Application for Membership and Life Insurance*



***Degree of Honor  
Protective Association***

*A Fraternal Benefit Society*

**287 West Lafayette Frontage Road, Suite 200  
Saint Paul, Minnesota 55107-3464  
Telephone: 651.228.7600, 800.947.5812  
[degreeofhonor.org](http://degreeofhonor.org)**

SERFF Tracking #:

GBAC-128821941

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Degree of Honor Protective Association

TOI/Sub-TOI:

L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life

Product Name:

DOH APP INSURANCE-13

Project Name/Number:

DOH APP INSURANCE-13/

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Cert of Compl-Reg 19.pdf			
AR Flesch Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Third Party Authorization Letter		
Comments:			
Attachment(s):			
Auth Generic Foundation[1].pdf			

**STATE OF ARKANSAS**

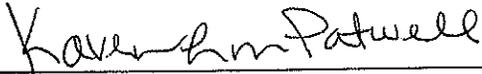
1200 West Third Street  
Little Rock, AR 72201

***Certification of Compliance  
Rule and Regulation 19***

Carrier: **Degree of Honor Protective Association**

Form Number and Title: APP INSURANCE-13F Application for Membership and Life Insurance

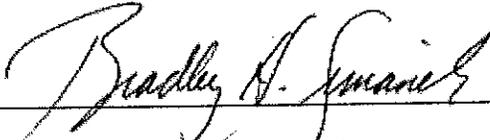
We hereby certify that to the best of our knowledge and belief the above submission complies with the Arkansas Rule and Regulation 19 as well as all applicable requirements of this department.

Signature of Officer: 

Name (typed or printed): Karen Patwell

Title or business affiliation: Controller/Secretary

Date: December 17, 2012

Signature of Actuary : 

Name (typed or printed): Bradley H. Simanek

Title or business affiliation: Consulting Actuary, Griffith, Ballard and Company

Date: December 17, 2012

STATE OF ARKANSAS

DEPARTMENT OF INSURANCE

1200 West Third Street  
Little Rock, AR 72201

CERTIFICATION

Readability Requirement

DEGREE OF HONOR PROTECTIVE ASSOCIATION hereby certifies that this filing complies with Ark. Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and achieves a Flesch reading ease test score as follows:

<u>Form #</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables/ Characters</u>	<u>Flesch Score</u>
APP INSURANCE-13F	153	4,145	34,239	47.3

  
\_\_\_\_\_  
Signature

Karen Patwell  
Name (Signed by Officer of Company)

Controller/Secretary  
Title



# Degree of Honor

Protective Association

Insurance with a heart

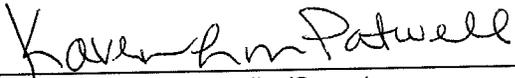
December 17, 2012

Re: DEGREE OF HONOR PROTECTIVE ASSOCIATION - NAIC #57088  
APP INSURANCE-13F Application for Membership and Life Insurance

To Whom it May Concern:

I HEREBY CERTIFY that Griffith, Ballard and Company has supervised the development of the form included in this submission, and that they are authorized to submit this form on behalf of DEGREE OF HONOR PROTECTIVE ASSOCIATION.

Any questions regarding this submission should be directed to Bradley H. Simanek of Griffith, Ballard and Company, Consulting Actuaries, as the individual responsible for this filing.

  
\_\_\_\_\_  
Karen Patwell, Controller/Secretary

**SERFF Tracking #:**

GBAC-128821941

**State Tracking #:****Company Tracking #:****State:**

Arkansas

**Filing Company:**

Degree of Honor Protective Association

**TOI/Sub-TOI:**

L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life

**Product Name:**

DOH APP INSURANCE-13

**Project Name/Number:**

DOH APP INSURANCE-13/

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/02/2013	Replaced 01/16/2013	Form	Application for Membership and Life Insurance	01/15/2013	Generic Foundation John Doe.pdf (Superseded)



# Degree of Honor Protective Association

287 W. Lafayette Frontage Road, Suite 200, Saint Paul, Minnesota, 55107-2464  
1-800-947-5812 • (651)228-7600 • Fax: (651)224-7446  
www.degreeofhonor.org

## Application for Membership and Life Insurance

**PLEASE PRINT WITH BLACK INK (medium point)**

**Identification Verification for any Proposed Insured and Owner.** The identification must be an unexpired government-issued identification card or document that includes a **photograph** and one or more of the following: driver's license number, taxpayer identification number, passport number and country of issuance, permanent resident identification number, or number and country of issuance of any other government-issued document evidencing nationality or residence.

**A. PROPOSED INSURED** Please print Mail policy to  Agent  Owner  Other \_\_\_\_\_

1. John Doe Date of Birth: 1-1-59  
First Name Middle Name Last Name

123 Main St  
Street Address - RFD - Box Number

Anywhere IA 00000  
City State Zip Code

2. Social Security Number 123-45-6789 3. U.S. State or Country of Birth IA 4. Age 54

5. Sex  Male  Female 6. Marital Status M 7. Former Last Name \_\_\_\_\_

8. E-mail address \_\_\_\_\_ 9. Driver's License # 00000

10. Daytime Phone # 111-111-1111 Evening Phone # \_\_\_\_\_

Best time to call: \_\_\_\_\_

11. Citizenship:  U.S.  Other \_\_\_\_\_ Date of arrival in U.S. \_\_\_\_\_

U.S. Permanent Resident card? (green card)  Yes  No If no, list Visa type: \_\_\_\_\_  
letter, number & expiration date

12. Employer Name and address: Acme Mfg

Duration(yrs): 20 Occupation/Duties: General

13. Individual Income \$ 30,000 Net Worth \$ 100,000 Household Income \$ 30,000

14. Type of ID(s) Drivers' License ID #(s) 00000

**B. PROPOSED SPOUSE RIDER INSURED** If being applied for:

1. \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Name Middle Name Last Name

Address if different than above

2. Social Security Number \_\_\_\_\_ 3. U.S. State or Country of Birth \_\_\_\_\_ 4. Age \_\_\_\_\_

5. Sex  Male  Female 6. Former Last Name \_\_\_\_\_

7. E-mail address \_\_\_\_\_ 8. Driver's License # \_\_\_\_\_

9. Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_

10. Citizenship:  U.S.  Other \_\_\_\_\_ Date of arrival in U.S. \_\_\_\_\_

U.S. Permanent Resident card? (green card)  Yes  No If no, list Visa type: \_\_\_\_\_  
letter, number & expiration date

11. Employer Name and address: \_\_\_\_\_

Duration(yrs): \_\_\_\_\_ Occupation/Duties: \_\_\_\_\_

12. Individual Income \$ \_\_\_\_\_

13. Type of ID(s) \_\_\_\_\_ ID #(s) \_\_\_\_\_

**C. OWNERSHIP** (Required if Proposed Insured is Under Age 18) Must comply with Fraternal Code

Owner (if other than Proposed Insured)

\_\_\_\_\_  
First Name Middle Name Last Name

\_\_\_\_\_  
Street Address - RFD - Box Number City State Zip Code

\_\_\_\_\_  
Relationship to Proposed Insured Home Telephone # E-mail Address Social Security # Date of Birth

Type of ID(s) \_\_\_\_\_ ID #(s) \_\_\_\_\_

**D. CONTINGENT OWNER** (Optional) Must comply with Fraternal Code

Owner

\_\_\_\_\_  
First Name Middle Name Last Name

\_\_\_\_\_  
Street Address - RFD - Box Number City State Zip Code

\_\_\_\_\_  
Relationship to Proposed Insured Home Telephone # E-mail Address Social Security # Date of Birth

Type of ID(s) \_\_\_\_\_ ID #(s) \_\_\_\_\_

**E. PRIMARY INSURED BENEFICIARY DESIGNATION** If more space is needed, use a separate paper.

Must comply with Fraternal Code.

Primary Beneficiary(ies)	SSN	%	Date of Birth	Relationship to Proposed Insured
Jane Doe	123-456780	100	1-1-59	Spouse

Contingent Beneficiary(ies)	SSN	%	Date of Birth	Relationship to Proposed Insured

If there is no surviving Beneficiary designated, the proceeds shall be paid to the Owner or the Owner's estate. Should the Owner or the Owner's estate fail to claim the funds within three years of the Insured's death, the funds shall be paid to the Degree of Honor Foundation.

**Beneficiary Designation if Spouse and/or Children's Riders are applied for:** The Beneficiary Designation on the Spouse and/or Children's Rider shall be the Primary Insured if living; otherwise the estate of the person insured by the Rider. The above shall apply unless otherwise indicated by a Beneficiary Designation form.

**F. SPECIAL REQUESTS** For example: special issue date. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**G. INSURANCE AND BENEFITS APPLIED FOR:**  New Policy  Change to Existing Policy # \_\_\_\_\_

1. Plan of Insurance Universal Life

2. Amount of Basic Plan \$ 25,000

a. For Universal Life Plans, is application for No Lapse Guarantee?  Yes  No

b. If No, Death Benefit Option  A - Level  B - Increasing

**3. Additional Benefit Riders**

Spouse Term (U.L. only) \$ \_\_\_\_\_ Primary Insured Term \$ \_\_\_\_\_

Children's Term (U.L. only) \$ \_\_\_\_\_ Accidental Death Benefit \$ \_\_\_\_\_

Monthly Disability Benefit (U.L. only) \$ \_\_\_\_\_ Disability Waiver (Traditional only)  Yes  No

Guaranteed Insurability Option (U.L.) \$ \_\_\_\_\_ Guaranteed Insurability Option (Traditional) \$ \_\_\_\_\_

Accelerated Death Benefit Rider  Yes  No If yes, submit the Accelerated Rider Disclosure form.

**H. PREMIUM INFORMATION**

1. Planned annual premium \$ 500.00 2. Amount paid per Conditional Receipt \$ 500.00

3. Method of payment  Monthly (EFT only)  Quarterly  Semi-annual  Annual  Single Premium  
 List Bill

4. Premium paid by  Check  Cash  Other \_\_\_\_\_

**I. DIVIDEND OPTION** (Traditional Only)  Paid in Cash  Paid-Up Additions  Accumulate at Interest

**J. AUTOMATIC PREMIUM LOAN** (Traditional Only)  Yes  No

**K. COMPLETE IF PROPOSED INSURED IS UNDER AGE 18** (Primary Insured only)

Is there similar insurance in force or applied for on all siblings?  Yes  No

If not, why? \_\_\_\_\_

Please list amount of life insurance already in force on parent(s)/guardian(s) \$ \_\_\_\_\_

**L. REPLACEMENT INFORMATION**

Does Proposed Insured have existing life insurance or annuities?  Yes  No

If applying for a Spouse Rider, does Proposed Spouse Insured have existing life insurance or annuities?  Yes  No

If "yes" to either question above, complete section below, and include any required Replacement Forms with your application.

**Existing Insurance Company Information:**

Company Name: \_\_\_\_\_ Policy or Contract # \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is the policy applied for intended to replace, change or borrow on any existing life insurance or annuity in this or any other company?  Yes  No If "yes", complete and submit any required replacement forms.

Expected 1035 exchange: \$ \_\_\_\_\_

**M. PROPOSED CHILD INSURED RIDER INFORMATION (if applied for)**

1. Name(s) of children to be covered by rider (must be under the age of 18 and unmarried)

Physical/Mental  
Abnormalities at Birth?  
(If yes, explain below)

Name (First, Middle, Last)	ID Number	Sex	Birthdate	Height	Weight

- Yes  No

2. Has any child listed above:

- a. Had a weight change during the last year? .....  Yes  No
- b. Received treatment for any disease, physical or mental condition, including ADD/ADHD in the past five years?.....  Yes  No

If yes to 1., 2a. or 2b. above, explain here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Are there any children under the age of 18 and unmarried not listed above?  Yes  No

If yes, List Name \_\_\_\_\_ Birthdate: \_\_\_\_\_

Reason for Exclusion: \_\_\_\_\_

4. Please list doctor's name(s), address(es) and phone number(s)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- N. WITHIN THE PAST 10 YEARS, HAS ANY PROPOSED INSURED HAD (including Spouse if Rider applied for. List details on page 6):**
- |  | YES                      | NO                                  |
|--|--------------------------|-------------------------------------|
| 1. A disorder of the blood, heart, or circulatory system; chest pain, heart murmur, heart attack, rheumatic fever, irregular heart beat, high blood pressure, PVD (peripheral vascular disease), varicose veins, stroke, memory loss, dementia, aneurysm, anemia or any other disorder of the heart, blood vessels or circulatory system?..... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Cancer, tumor, cyst, growth, or enlargement of the lymph glands?.....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. A disorder of the respiratory system; asthma, bronchitis, COPD, emphysema, tuberculosis, sleep apnea, shortness of breath or other lung disorders?.....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. A disorder of the digestive system; ulcer, colitis, rectal bleeding, diarrhea, hepatitis or other disorders of the stomach, esophagus, intestines, liver or gallbladder?.....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Diabetes, thyroid, adrenal, pituitary or other glandular disorder?.....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Albumin, blood, sugar or pus in the urine; any disorder of the kidney or bladder?.....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Epilepsy, convulsions, loss of consciousness, dizziness, paralysis, headaches, depression, anxiety, mental, emotional or nervous disorder, mental retardation or cerebral palsy?.....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. A disorder of the muscles, skin, or bone; arthritis, gout, connective tissue disorder or disorders of the back, joints, or extremities?.....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. A disorder of the reproductive system including prostate, testes, breast(s), ovaries or uterus, sexually transmitted disease, HPV, or current pregnancy?.....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. A disorder of the eyes, ears, nose, throat, or mouth?(other than glasses or contacts).....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- O. WITHIN THE PAST 5 YEARS HAS ANY PROPOSED INSURED (including Spouse if Rider if applied for. List details on page 6):**
- |   | YES                                 | NO                                  |
|---|-------------------------------------|-------------------------------------|
| 11. Had a medical checkup, sought or received medical advice or been advised to restrict normal activities because of illness or injury (including x-rays, ECGs, other tests or medication)?..... | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 12. Been treated or evaluated at a hospital, clinic or other facility by a medical professional or been advised by a medical professional to have any test or surgery not yet completed?.....     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 13. Consulted a hospital, clinic, psychiatrist, psychologist, or counselor for any reason?.....   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 14. Been refused a motor vehicle driver's license, had a license suspended, a moving traffic violation, or been cited for a DUI/DWI? (If "yes", give date, type of violation, and state).....     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 15. Used marijuana, cocaine, heroin, amphetamines or any other controlled or prohibited substances?.....<br>If Yes, give date last used: _____  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 16. Been treated for, received counseling, or been advised to seek counseling by a medical professional because of alcohol or drug usage?.....  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
- P. HAS ANY PROPOSED INSURED (including Spouse if Rider applied for. List details on page 6):**
- |  | YES                      | NO                                  |
|--|--------------------------|-------------------------------------|
| 17. Ever been diagnosed by a member of the medical profession or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an AIDS-related condition; or tested positive for the Human Immunodeficiency Virus (HIV)?.... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 18. Received any medical advice, treatment, or surgery or presently have a physical impairment or illness not already listed?.....   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19. Ever had a life or health insurance application declined, postponed, rated, modified or withdrawn? (If "yes", give name of company(ies), date, and reason).....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20. Within the past two years flown as a pilot, co-pilot, student pilot, or crew member?.....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 21. Within the past two years participated in any of the following: scuba diving, skydiving, ultra-light flying, hang-gliding, or auto, boat, motorcycle or snowmobile racing?.....  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**LIST DETAILS OF ANY "YES" ANSWERS FROM PAGE 5, INCLUDING SPOUSE**

*If more space is needed, use page 2*

Question Name Number	Illness-Medication-Treatment-Restrictions or Explanation of Nonmedical "Yes" Answer	Date Began	Date Recovered	Doctor-Hospital-Medical Facility Address-telephone Number
-------------------------	--	---------------	-------------------	--

<u>0-11 John</u>	<u>Normal Check-up</u>	<u>12-1-12</u>	<u>Dr Jones</u>

**Q. INFORMATION FOR PROPOSED INSURED(S)**

**1. Proposed Insured**

Height 6' 0" Weight 200 Weight One(1) Year Ago 200 Reason for Weight Change \_\_\_\_\_

Have you used nicotine in any form within the 12 months?  Yes  No

If "yes",  Pipe or Cigars  Smokeless  Cigarettes  Nicotine patch, gum, spray

How often? \_\_\_\_\_ How many? \_\_\_\_\_ Date last used: \_\_\_\_\_

Primary physician or clinic (If none, check ) \_\_\_\_\_  
Name

Street Address, City, State, Zip Code \_\_\_\_\_ Telephone Number with Area Code \_\_\_\_\_

Date and reason last consulted \_\_\_\_\_

Results, type of treatment and/or medication \_\_\_\_\_

**2. Proposed Spouse Rider Insured (if applied for)**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight One(1) Year Ago \_\_\_\_\_ Reason for Weight Change \_\_\_\_\_

Have you used nicotine in any form within the 12 months?  Yes  No

If "yes",  Pipe or Cigars  Smokeless  Cigarettes  Nicotine patch, gum, spray

How often? \_\_\_\_\_ How many? \_\_\_\_\_ Date last used: \_\_\_\_\_

Primary physician or clinic (If none, check ) \_\_\_\_\_  
Name

Street Address, City, State, Zip Code \_\_\_\_\_ Telephone Number with Area Code \_\_\_\_\_

Date and reason last consulted \_\_\_\_\_

Results, type of treatment and/or medication \_\_\_\_\_

**3. Has any Proposed Insured's parents, brothers, or sisters ever had**

	Cancer	High Blood Pressure	Heart Disease	Congenital Disorder	Mental Illness	Diabetes	None
Proposed Insured	<input type="checkbox"/>	<input checked="" type="checkbox"/>					
Proposed Spouse Insured	<input type="checkbox"/>	<input checked="" type="checkbox"/>					

If so, give relationship, condition, current age or age of death \_\_\_\_\_

**ACKNOWLEDGEMENT**

**I understand and agree that:**

1. I have read and received the Notice of Insurance Information Practices and the MIB, Inc. Pre-Notice. I authorize Degree of Honor Protective Association, or its reinsurers, to make a brief report of my personal health information to MIB.
2. I have read the previous statements and answers and to the best of my knowledge they are true and complete.
3. This application shall become part of the insurance contract together with our Articles of Incorporation and Bylaws, as amended from time to time.
4. No change in this application shall be made without my written consent.
5. No agent of Degree of Honor Protective Association is authorized to make or alter any contract or waive any Degree of Honor Protective Association rights or requirements.
6. No insurance shall take effect (unless otherwise provided in a completed Conditional Receipt) until:
  - a) the Policy is delivered and you accept it;
  - b) the first full premium is paid by check, money order or cashiers check made payable only to Degree of Honor Protective Association during the lifetime of the Insured; and
  - c) the insurability of the Proposed Insured remains as described in this application and all representations are true and correct.

Signed at Anywhere IA, on 1-1-2013  
City, State Date

John Doe  
 Signature of Proposed Insured, age 15 or older (primary Insured only)

Signature of Spouse if Spouse Rider Applied For

Signature of Parent/Guardian, if under age 18

Agent  
 Authorized Agent

Signature of Owner if different than Proposed Insured

**COLORADO Fraud Warning:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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

**OKLAHOMA: WARNING:** Any person who knowingly, and 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.

**TENNESSEE AND WASHINGTON Fraud Warning:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**TEXAS Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

**ILLUSTRATION CERTIFICATION**

I have received an illustration with this application.  Yes  No (If "no", complete acknowledgement below)

**Owner Acknowledgement**

I did not receive an illustration at the time I applied for my Degree of Honor Protective Association life insurance policy. I understand that an illustration conforming to the policy issued shall be provided no later than at the time of policy delivery.

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

**Authorized Agent Acknowledgement**

I certify that I did not present an illustration to the above-named Owner at the time of application.

Signature of Authorized Agent \_\_\_\_\_ Date \_\_\_\_\_

**LODGE/SERVICE CLUB MEMBERSHIP** Must be signed. Not applicable for Proposed Insureds age 17 or less.

Is(Are) Proposed Insured(s) now a member of the Association?  Yes Lodge/Service Club # 530 State AZ  
 No (If "no", complete membership application below)

**APPLICATION FOR MEMBERSHIP TO DEGREE OF HONOR PROTECTIVE ASSOCIATION**

I **hereby apply** for membership in the Association and its local Lodge/Service Club # \_\_\_\_\_ State of \_\_\_\_\_  
I **understand** that unless I select a specific Lodge/Service Club, the Association will select the Lodge/Service Club to which I will be assigned membership.

I **agree** if accepted, to abide by the Articles of Incorporation and Bylaws of the Association and the Bylaws of said Lodge/Service Club, all as the same now exist or are hereafter amended.

I **hereby affirm** my belief in: Christian beliefs and values and demonstration of high moral character. The protection and support of family members and their dependents through fraternal insurance products. Promotion of the family unit and the seeking of ways to strengthen it. Assistance to members, their dependents and others in times of adversity. The desire to help others in need through community service and adherence to the principals of volunteerism. Maintenance of a representative form of government by providing members with the opportunity to become involved in structured events, club meetings and programs. Respect for and allegiance to the United States of America and its flag by promoting patriotism. Adherence to the Golden Rule "Do unto others as you would have them do unto you."

Signature of Proposed Member \_\_\_\_\_ Date \_\_\_\_\_

Signature of Proposed Member \_\_\_\_\_ Date \_\_\_\_\_

**ELECTRONIC FUNDS TRANSFER** I hereby authorize Degree of Honor Protective Association to initiate automatic premium payments to be charged to my account shown below and the Financial Institution named below to charge these premiums to such account. **Name of Financial Institution** \_\_\_\_\_

**Routing #** \_\_\_\_\_ **Account #** \_\_\_\_\_

**EFT WITHDRAWAL ACCOUNT**  Checking Account\*  Savings Account\*\*

\* If choosing EFT from **Checking Account**, attach a voided check for account and transit numbers.

\*\* If choosing EFT from **Savings Account**, attach a voided withdrawal slip with the preprinted account and transit numbers.

Draft my account for the first premium **ONLY** (initial premium may be drafted upon receipt of this application).

Draft my account for ongoing monthly premium payments **ONLY**.

Draft my account for **BOTH** first premium and ongoing monthly premium payments.

**COMPLETE FOR ONGOING PREMIUM PAYMENTS:**

**EFT WITHDRAWAL DATE BUSINESS DAY OF THE MONTH**  1st Day  8th Day  16th Day  23rd Day

**NOTICE TO POLICYHOLDERS:** This authority is to remain in full force and effect until the Financial Institution has received written notification from you of its termination in such time and in such manner as to afford the Financial Institution a reasonable opportunity to act on it. The Policyholder has the right to stop payment of a premium by notification to the Financial Institution prior to charging the account. After the account has been charged, a customer has the right to have the amount of an erroneous payment immediately credited to his(her) account by the Financial Institution up to 15 days following notification.

No premium payment shall be deemed to have been paid until Degree of Honor receives actual payment in its office, and the account, check or draft has been honored. Degree of Honor shall incur no liability as a result of the dishonor of any account debit, check or draft made under this authorization.

Name(s) (Please print) \_\_\_\_\_

Signature \_\_\_\_\_ 2nd Signature if Joint Account \_\_\_\_\_

**AGENT'S CONFIDENTIAL REPORT**

1. Did you personally see the Proposed Insured and ask each question?  Yes  No
2. Did the Proposed Insured contact you for this insurance?  Yes  No
3. Purpose for insurance?  Estate liquidity (estate taxes, clearance costs)  Business insurance (Give details. Must comply with Fraternal Code.)  Family income (survivor, retirement, etc)  Other personal needs (personal loan)  
 Other \_\_\_\_\_
4. How well do you know the Proposed Insured?  Very well  Casually  Just met  Relative  
 If a relative, please explain relationship; \_\_\_\_\_
5. Are any other family members who are not on this application applying for insurance at this time?  Yes  No

Name(s) & Date	Relationship to Proposed Insured	Company	Plan/Amount

6. Indicate type of arrangements made:
- |                       |                                     |                          |                          |                            |                          |                          |
|-----------------------|-------------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
|                       | Nonmedical                          | Basic<br>Paramed         | H.O. Urine<br>specimen   | Blood<br>chemistry profile | ECG                      | Other<br>(explain below) |
| Proposed Insured      | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Proposed Spouse Rider | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |

Other (indicate) \_\_\_\_\_

Name of paramedical facility or medical doctor being used \_\_\_\_\_  
 Scheduled date of completion \_\_\_\_\_ Telephone # \_\_\_\_\_

7. Was the premium paid with this application?  Yes  No
8. Who paid the premium?  Owner  Proposed Insured  Other (explain below)
9. Additional information and explanations: \_\_\_\_\_

**SALES VERIFICATION**

This must be completed if applicant answered yes to any question listed on page 3 under the Replacement Information section.

I hereby verify the following in connection with this application for life insurance applied for that only the following Degree of Honor Protective Association approved preprinted sales materials were used:

1. Illustration
2. \_\_\_\_\_
3. \_\_\_\_\_

and that copies of all individualized sales materials including but not limited to, sales illustrations and financial needs analyses related to the specific policy or contract purchased are herewith enclosed with this application.

Agent Signature: Agent Date 1-1-2013

**To the best of my knowledge and belief:**

1. I have asked all questions and recorded all answers as they were given to me by the Proposed Insured and/or Owner.
2. I know nothing about Proposed Insured's health, habits, avocations or life style affecting insurability which has not been stated in this application.
3. The Proposed Insured  does  **does not** have existing life insurance policies or annuity contracts.
4. The insurance applied for on this application  is  **is not** intended to replace or change any life insurance or annuity with this or any other organization, except as indicated. Section I must be completed.
5. The Notice of Insurance Information Practices and MIB, Inc. Pre-Notice and disclosure or outline(s) of coverage, if required, were left with the Proposed Insured and Owner.
6. I have explained the anti-money laundering/terrorist financing information collecting requirements to the Owner and Proposed Insured.
7. I  **have seen**  **have not seen** the Owner's photo ID and verified such identity.  
I  **have seen**  **have not seen** the Proposed Insured's photo ID (as applicable) and verified such identity(ies).

DATED 1-1-2013 SIGNED agent Authorized Agent

**AGENT PERSISTENCY NUMBER IS REQUIRED. PLEASE FULLY COMPLETE THIS SECTION.**

<u>00000</u> Persistence Number	_____
<u>Agent</u> Print Agent's Name	_____
<u>Agent</u> Agent's Signature	_____
Agent's E-mail Address	Agent's Telephone Number
_____	_____
<u>100</u> Percent (%)	_____
	Percent (%)

**CONDITIONAL RECEIPT**

Detach and deliver to applicant only if first premium is received.

- A. WHEN INSURANCE IS EFFECTIVE. It is mutually agreed that the insurance applied for will take effect prior to delivery of a policy as of the latest of the date hereof or the date of any required medical examination only if: (1) the application is fully and truthfully completed; (2) all medical examinations required by our published underwriting rules have been completed; (3) the Proposed Insured(s) is(are) eligible as of the Policy Date for the plan and amount of insurance applied for; (4) the Proposed Insured(s) is(are) approved as an insurable risk at standard rates under Association rules after receipt of required information; and (5) the required first full premium is paid by check, money order or cashiers check made payable to Degree of Honor Protective Association.
- B. WHEN RECEIPT IS VOID. This receipt shall be void and no insurance shall be in force hereunder if: (1) any of the required conditions in A above are not fulfilled; or (2) if any plan or amount applied for is declined or is not approved for issuance within 60 days of the date of the application; or (3) if a check in payment of premium is not honored on first presentation; or (4) if death occurs as a result of suicide or attempted suicide.

NO AGENT OR REPRESENTATIVE OF THE ASSOCIATION IS AUTHORIZED TO WAIVE ANY OF THE FOREGOING CONDITIONS

Received from John Doe the sum of 500.00 as first premium for application  
Please print

Dated 1-1-2013 relating to John Doe  
Proposed Insured(s)

subject to the foregoing terms and conditions.

Degree of Honor Protective Association  
287 W. Lafayette Frontage Road, Suite 200  
Saint Paul, Minnesota 55107-3464  
Telephone: 651.228.7600, 800.947.5812  
degreeofhonor.org

\_\_\_\_\_  
Authorized Agent



**NOTICE OF INSURANCE INFORMATION PRACTICES and MIB, INC. PRE-NOTICE**  
**Always detach and give to the Proposed Insured or Parent or Guardian**

Degree of Honor Protective Association appreciates your application and the confidence you have shown in us. Information regarding insurability is necessary to equitably evaluate your application. All information will be treated as confidential. Sources for this information include statements made on the application or possibly in a telephone interview from the Home Office, examination results, medical studies, and reports we receive from doctors, practitioners, medical facilities, the MIB, Inc., or from investigative consumer reports.

Degree of Honor and its reinsurers may make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734; telephone number 866-692-6901 (TTY 866-346-3642). Degree of Honor, or its reinsurers, may also release information from its file to other insurance companies to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

In addition, we may get an investigative report from a consumer reporting agency. This report may include personal interviews with your neighbors, friends or other acquaintances for information as to your general reputation, personal characteristics and mode of living. No information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance. Upon written request, you will be informed if such a report was obtained and, if so, the name and address of the consumer reporting agency to whom such a request was made. You may contact that agency and ask for a copy of this report.

Upon request, Degree of Honor will furnish details on how to obtain and correct personal information in its file.

*Application for Membership and Life Insurance*



***Degree of Honor  
Protective Association***

*A Fraternal Benefit Society*

**287 West Lafayette Frontage Road, Suite 200  
Saint Paul, Minnesota 55107-3464**

**Telephone: 651.228.7600, 800.947.5812**

**[degreeofhonor.org](http://degreeofhonor.org)**