WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY
1700 Farnam Street Omaha, Nebraska 68102

APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE WITH CHILD BENEFITS AND MEMBERSHIP

New Certificate Number: ____________ This Change to Affect Certificate Number: ____________

Field Representative Code: ____________ ☐ New Certificate ☐ Change Existing Certificate ☐ Reinstatement

1 PROPOSED PRIMARY INSURED/APPLICANT (Proposed primary insured will be owner and must be ages 18 through 50.)

First	Middle Initial	Last	Suffix	Social Security Number

Street Address (Residence of Proposed Primary Insured)	Apt/Unit #

City	State	Zip

Mailing Address if Different from Residence	City	State	Zip

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Rating Age	Birth Location	Telephone Day Eve

Is the primary residence of all proposed insureds the same as that of the Proposed Primary Insured/Applicant? . . . YES ☐ NO ☐

If "No", give name(s) and provide explanation:

2 PROPOSED OTHER INSURED/APPLICANT (Proposed other insured will be owner and must be ages 18 through 50.)

First	Middle Initial	Last	Suffix	Social Security Number

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Rating Age	Birth Location	Telephone Day Eve

3 PROPOSED INSURED CHILDREN

Number of children applying for insurance: ____________

If more than FOUR children, complete supplementary statement in place of this section.

First	Middle Initial	Last	Suffix	Social Security Number

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:

☐ New Member ☐ Existing Member

First	Middle Initial	Last	Suffix	Social Security Number

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:

☐ New Member ☐ Existing Member

First	Middle Initial	Last	Suffix	Social Security Number

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:

☐ New Member ☐ Existing Member

First	Middle Initial	Last	Suffix	Social Security Number

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Relationship of Proposed Primary Insured & Proposed Other Insured to Child Primary Insured: Other Insured:

☐ New Member ☐ Existing Member

4 FAMILY LODGE MEMBERSHIP

Lodge membership assignments will be determined by the Home Office.

Proposed Primary Insured ☐ New Member ☐ Existing Member

Proposed Other Insured ☐ New Member ☐ Existing Member

5 TYPE OF CHANGE

☐ Consider for possible rate reduction/removal	☐ Proposed Primary Insured	☐ Proposed Other Insured
☐ Consider for non-tobacco classification	☐ Proposed Primary Insured	☐ Proposed Other Insured
☐ 90 day change	☐ Proposed Primary Insured	☐ Proposed Other Insured

6 TERM LIFE INSURANCE WITH CHILD BENEFITS

Proposed Primary Insured Face Amount:		Proposed Other Insured Face Amount:	
☐ $50,000	☐ $100,000	☐ $50,000	☐ $100,000
☐ $250,000	☐ $500,000	☐ $250,000	☐ $500,000

- Face amount for Proposed Other Insured cannot exceed face amount applied for by Proposed Primary Insured.
- Face amount for all Proposed Insured Children will be $10,000.

RIDERS

Accelerated Death Benefit Rider (included unless "No" checked here) . . . . . ☐ No ☐ Add ☐ Remove

Disability Waiver of Premium Rider (For issue ages 18 through 50 years only) . . . . . ☐ Add ☐ Remove

7 REFUND OPTION (Choose only one.)

Unless specifically stated otherwise in your contract, if no option, more than one option, or an unavailable option is checked, refunds will be left with Woodmen at interest.

☐ Cash ☐ Apply to reduce annual premium (Not available with Pre-Authorized Collection)

☐ Left with Woodmen at interest

8 BENEFICIARY

BENEFICIARY DESIGNATION FOR PROPOSED OTHER INSURED ONLY (If Applicable)

Proposed Primary Insured if living, otherwise the estate of the Other Insured. **This beneficiary designation cannot be changed.**

BENEFICIARY DESIGNATION FOR PROPOSED INSURED CHILDREN ONLY (If Applicable)

Owner who is the natural parent, adoptive parent, or permanent legal guardian, equally or to the survivor, otherwise the estate of the deceased insured child. **This beneficiary designation cannot be changed.**

BENEFICIARY DESIGNATION FOR PROPOSED PRIMARY INSURED ONLY

- For **changes**: Completion of this section will revoke all previous beneficiary designations for the Proposed Primary Insured.

Primary Beneficiary

Name	City	State	Relationship	Age or Date of Birth	Social Security No./ Tax ID Number

Alternate Beneficiary

Name	City	State	Relationship	Age or Date of Birth	Social Security No./ Tax ID Number

UNLESS OTHERWISE STATED IN WRITING, THE FOLLOWING CONDITIONS APPLY:

- The death benefit, when paid to all surviving primary beneficiaries, is paid equally in one sum.
- If there are no surviving primary beneficiaries, the death benefit is paid equally in one sum to all surviving alternate beneficiaries.
- The beneficiary will have the right to change the method by which the death benefit is paid after the death of an insured.

9 TOBACCO USAGE

In the past **12 months**, has either proposed insured (Primary/Other) used tobacco in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum?	Proposed Primary Insured YES	Proposed Primary Insured NO	Proposed Other Insured YES	Proposed Other Insured NO
	☐	☐	☐	☐

Proposed Primary Insured

A. If "Yes", indicate date last used:

Mo. _____ Yr. _____

Indicate form(s) used: _____

If cigarettes, how many packs per day? _____

If cigars, indicate quantity and frequency:

_____

Proposed Other Insured

A. If "Yes", indicate date last used:

Mo. _____ Yr. _____

Indicate form(s) used: _____

If cigarettes, how many packs per day? _____

If cigars, indicate quantity and frequency:

_____

B. If "No", has either proposed insured (Primary/Other) used tobacco in any form OR smoking cessation products in the last **36 months**?	YES	NO	YES	NO
	☐	☐	☐	☐

10 OCCUPATION

Proposed Primary Insured

Occupation and Duties	Annual Income (Nearest $10,000)	How Long in Present Occupation?
Name of Employer and Nature of Business	Address of Business	Previous Occupation

Proposed Other Insured

Occupation and Duties	Annual Income (Nearest $10,000)	How Long in Present Occupation?
Name of Employer and Nature of Business	Address of Business	Previous Occupation

11 NONMEDICAL

A. Does the Proposed Primary Insured have a current driver's license/permit? ☐ Yes, Driver's License/Permit Number:

_____ State: _____

☐ No, explain why no license/permit:

_____

A. Does the Proposed Other Insured have a current driver's license/permit? ☐ Yes, Driver's License/Permit Number:

_____ State: _____

☐ No, explain why no license/permit:

_____

HAS OR IS THE PROPOSED PRIMARY INSURED OR THE PROPOSED OTHER INSURED:	Proposed Primary Insured YES	Proposed Primary Insured NO	Proposed Other Insured YES	Proposed Other Insured NO
B. Currently a United States citizen?	☐	☐	☐	☐
If "No", give name and provide permanent resident card number:				
C. Ever had a license/permit suspended or revoked?	☐	☐	☐	☐
D. Had any moving traffic violations or traffic accidents within the past three years?	☐	☐	☐	☐
E. Been convicted of or pled guilty or no contest to driving while intoxicated or under the influence of a narcotic drug?	☐	☐	☐	☐
F. Been convicted of or pled guilty or no contest to a crime within the past 10 years, or is either proposed insured currently awaiting trial for any crime?	☐	☐	☐	☐
G. Currently on probation or parole?	☐	☐	☐	☐
H. A member of the U.S. Armed Services or active reserve?	☐	☐	☐	☐
If "Yes" has either proposed insured been alerted of possible deployment?	☐	☐	☐	☐

If any question C-H has been answered "Yes", give dates and full details at the top of Page 4 of this application.

11 NONMEDICAL, Continued

Give dates and full details for the Proposed Primary Insured.

Give dates and full details for the Proposed Other Insured.

HAS OR IS THE PROPOSED PRIMARY INSURED OR THE PROPOSED OTHER INSURED:	Proposed Primary Insured YES	NO	Proposed Other Insured YES	NO
I. Planning within the next 12 months to travel or reside outside of the U.S., Canada or any U.S. territories? If "Yes" submit details on Form ICC09 956F.	☐	☐	☐	☐
J. Participated in aviation as a pilot, crew member or student in the past 3 years – to include sky diving, hang gliding, ballooning, ultralight, and other sky sports – or intends to within the next 2 years? If "Yes", submit an Aviation Questionnaire.	☐	☐	☐	☐
K. Participated in racing of any type, skin or scuba diving, boxing, ultimate fighting or mountain climbing in the past 3 years – or intends to within the next 2 years? If "Yes", submit an Avocation Questionnaire.	☐	☐	☐	☐

12 MEDICAL

1. PHYSICIAN OR MEDICAL FACILITY THAT HAS THE MOST COMPLETE AND CURRENT MEDICAL RECORDS:

Proposed Primary Insured

Physician/Facility Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____ Date Last Seen _____

Proposed Other Insured

Physician/Facility Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____ Date Last Seen _____

2. HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) EVER BEEN DIAGNOSED, TREATED, TESTED POSITIVE FOR OR BEEN GIVEN MEDICAL ADVICE BY A MEMBER OF THE MEDICAL PROFESSION FOR ANY DISEASE OR DISORDER OF THE:	Proposed Primary Insured YES	NO	Proposed Other Insured YES	NO
A. Brain or Nervous System – such as epilepsy, paralysis or mental illness – to include treatment or counseling for depression or anxiety?	☐	☐	☐	☐
B. Respiratory System – such as emphysema, bronchitis or asthma – to include disorders of the eyes, ears, nose or throat?	☐	☐	☐	☐
C. Circulatory System – such as high blood pressure, chest pain, heart attack, heart surgery, heart murmur, stroke, or phlebitis?	☐	☐	☐	☐
D. Digestive or Urinary Tract Systems – such as ulcer, colitis, hepatitis, kidney infection, kidney stones, protein, blood or sugar in the urine – to include diabetes and thyroid disorders?	☐	☐	☐	☐
E. Musculoskeletal System – such as arthritis, gout, back disorders, or any connective tissue disorders?	☐	☐	☐	☐
F. Reproductive System – such as prostate, testes, breasts, ovaries or uterus disorders?	☐	☐	☐	☐
G. Immune System – such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus?	☐	☐	☐	☐
3. HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) EVER:				
A. Been diagnosed or treated by a member of the medical profession for cancer or tumor of any kind?	☐	☐	☐	☐
B. At any time in the past five years had or been advised by a member of the medical profession to have any surgical operation?	☐	☐	☐	☐
C. Been treated or received counseling for alcohol use, alcoholism or drug addiction? If "Yes", submit an Alcohol & Drug Questionnaire	☐	☐	☐	☐
D. Used narcotics, barbiturates, excitant drugs, hallucinogens or tranquilizers without a prescription by a physician? If "Yes", submit an Alcohol & Drug Questionnaire.	☐	☐	☐	☐

If any medical question has been answered "Yes", give dates and full details on Page 5 of this application.

12 MEDICAL, Continued

		Proposed Primary Insured		Proposed Other Insured	
		YES	NO	YES	NO
4.	HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) BEEN DIAGNOSED BY A MEMBER OF THE MEDICAL PROFESSION OR TESTED POSITIVE FOR HUMAN IMMUNODEFICIENCY VIRUS (AIDS VIRUS) OR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)? . . . . . 4.	☐	☐	☐	☐
5.	AT ANY TIME IN THE PAST FIVE YEARS, HAS EITHER PROPOSED INSURED (PRIMARY/OTHER) BEEN TREATED OR DIAGNOSED BY A MEDICAL PROFESSIONAL WITH ANY OTHER ILLNESS OR INJURY NOT MENTIONED ABOVE? . . . . . 5.	☐	☐	☐	☐
6.	DURING THE PAST FIVE YEARS HAS EITHER PROPOSED INSURED (PRIMARY/OTHER):				
	A. Consulted, been examined by, treated by or received diagnostic tests (e.g., X-rays, ECG, or blood studies except those tests related to the Human Immunodeficiency Virus (AIDS Virus)) from a physician, hospital, clinic or similar institution? . . . . . A.	☐	☐	☐	☐
	B. Received a pension, applied for or been compensated for disability? If "Yes", please explain B.	☐	☐	☐	☐
	C. Had an application for life, health, accident or disability insurance declined, postponed, rated up or modified? If "Yes", please explain what action was taken and why . . . . . C.	☐	☐	☐	☐
7.	DOES EITHER PROPOSED INSURED (PRIMARY/OTHER) TAKE MEDICATION? If "Yes", state name of drug and condition requiring it . . . . . 7.	☐	☐	☐	☐
8.	A. IS EITHER PROPOSED INSURED (PRIMARY/OTHER) NOW PREGNANT? If "Yes", indicate due date . . . . . A.	☐	☐	☐	☐
	B. Has there been a diagnosis or treatment by a member of the medical profession for complications of this pregnancy?. . . . . B.	☐	☐	☐	☐
9.	A. PROPOSED PRIMARY INSURED'S HEIGHT: _____ ft. _____ in. WEIGHT: _____ lbs.				
	B. PROPOSED OTHER INSURED'S HEIGHT: _____ ft. _____ in. WEIGHT: _____ lbs.				
	C. Has weight changed more than 15 pounds for either proposed insured in the past year? . . . C.	☐	☐	☐	☐
	If "Yes", give name and indicate how much and by what means:				

_____

If any question 2-8 has been answered "Yes" by the Proposed Primary Insured, give full details below:

Question Number	Diagnosis/Treatment/Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If any question 2-8 has been answered "Yes" by the Proposed Other Insured, give full details below:

Question Number	Diagnosis/Treatment/Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If more space is needed for Medical details, include an additional page, signed, dated and witnessed.

13 FAMILY HISTORY

		Proposed Primary Insured		Proposed Other Insured	
	FOR EITHER PROPOSED INSURED (PRIMARY/OTHER):	YES	NO	YES	NO
A.	Have parents or siblings been diagnosed or treated by a member of the medical profession for cardiovascular disease or cancer prior to age 60?	☐	☐	☐	☐
	If "Yes", give proposed insured's name and details _____				
B.	Did death of a parent or sibling occur prior to age 60 due to cardiovascular disease or cancer? . .	☐	☐	☐	☐

14 CHILDREN MEDICAL If more than FOUR children, complete supplementary statement in place of this section.

		YES	NO
1.	Have any proposed insured children been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes", give child's name and details below.	☐	☐
2.	Have any proposed insured children been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any of the following diseases or disorders: If "Yes", give child's name and details below.		
	A. Any physical or mental impairment due to illness, injury or birth defect?	☐	☐
	B. Any heart condition or heart surgery of any kind?	☐	☐
	C. Any alcohol or drug abuse?	☐	☐
	D. Any cancer, including melanoma but excluding other types of skin cancers?	☐	☐
	E. Diabetes?	☐	☐
	F. Immune deficiency disorder such as lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus (AIDS Virus)?	☐	☐
3.	In the past 24 months, have any of the proposed insured children been seen by a physician or treated in a medical facility for an illness or disease? If "Yes", give child's name and details below.	☐	☐
4.	Are any of the proposed insured children currently taking medication(s)? If "Yes", give child's name, name of drug and condition requiring it below.	☐	☐

If any question 1-4 has been answered "Yes", give child's name and full details below:

Question Number	Child's Name	Details

If more space is needed for Children's Medical details, include an additional page, signed, dated and witnessed.

15 INSURANCE NOW IN FORCE OR APPLIED FOR AND REPLACEMENT

◆ **If more than two policies, complete a supplementary statement.**

FOR EITHER PROPOSED INSURED (PRIMARY/OTHER):	Proposed Primary Insured YES	Proposed Primary Insured NO	Proposed Other Insured YES	Proposed Other Insured NO
A. Does the proposed applicant have any existing life insurance or annuity contracts?	☐	☐	☐	☐
B. Will any existing life or annuity contracts be replaced if the proposed certificate is issued?	☐	☐	☐	☐

If A or B is answered "Yes", provide policy number and company information below. Submit replacement forms, if required.

Proposed Primary Insured List all policies currently **in force** or **applied for.** **If none, check here.** ☐

Company Name _____ Policy Number _____

Address _____ City _____ State _____ Zip _____

Kind _____ Life Amount _____ Replace ☐ YES ☐ NO

Company Name _____ Policy Number _____

Address _____ City _____ State _____ Zip _____

Kind _____ Life Amount _____ Replace ☐ YES ☐ NO

Proposed Other Insured List all policies currently **in force** or **applied for.** **If none, check here.** ☐

Company Name _____ Policy Number _____

Address _____ City _____ State _____ Zip _____

Kind _____ Life Amount _____ Replace ☐ YES ☐ NO

Company Name _____ Policy Number _____

Address _____ City _____ State _____ Zip _____

Kind _____ Life Amount _____ Replace ☐ YES ☐ NO

16 PREMIUM DEPOSIT

☐ 1. Cash or Check Amount: $ _____ ☐ 2. Refunds on Deposit

☐ 3. Cash Surrender Value Amount: $ _____ ☐ 4. Credit Card ☐ 5. Express Check

Total Amount Collected: $ _____

Includes premium and fraternal dues of [$2.50] per month as payment for _____ months.

If 1-5 is selected on an application for a new certificate, give conditional receipt to applicant; if 2, 3 or 4 is selected, also submit proper authorization.

P.A.C. authorizations and List Bill to companies other than Woodmen are NOT premium deposits for RECEIPT AND CONDITIONAL INSURANCE AGREEMENT purposes.

17 FUTURE BILLING

Billing Method

☐ New P.A.C. plan (submit Form 98D)

☐ Add to present P.A.C. plan (list one certificate number currently being paid on plan)

CERTIFICATE NO. _____

Payor's Name: _____

Bank Acct. No.: _____

☐ Direct Bill

☐ List Bill *

Group Number: _____

* Submit proper authorizations

Frequency

☐ Annually

☐ Semiannually

☐ Quarterly

☐ Monthly *

* Not Available for direct bill.

18 PAYOR INFORMATION (Complete if not the proposed primary insured/applicant.)

First Middle Initial Last Suffix

Address Apt/Unit #

City State Zip

Relationship to Proposed Primary Insured Date of Birth (MM/DD/YYYY) Social Security No./ Tax ID Number

19 ACKNOWLEDGEMENT AND AGREEMENT

The following statements must be read by or to the applicant(s): I have received a copy of the "Notice Relating to the MIB (Medical Information Bureau)", "Notice Required Under the Fair Credit Reporting Act" and if applicable the "Notice of Information Practices". The Accelerated Death Benefit Disclosure Statement has been given to me, the applicant, if applicable.

I have read this application. I represent that each of the answers and the information given therein is full, complete and true, to the best of my knowledge and belief with the understanding that they shall be considered as representations and not warranties. I agree as follows:

1. Notice to or knowledge of any field representative or medical examiner as to information which relates to any proposed insured will not be notice to Woodmen unless it is in writing in this application.
2. Field Representatives do not have authority to (a) determine insurability; (b) change any terms of this application; (c) make or change a contract for Woodmen; (d) waive any rights or requirements of Woodmen. I understand that oral statements between the Field Representative and myself regarding such matters of limited authority are not binding on Woodmen unless accepted by Woodmen in writing.

I agree to be bound by the terms of this application and the life insurance certificate for which I am applying. I also agree to be bound by all obligations of membership set forth in Woodmen's Articles of Incorporation and its Constitution and Laws and acknowledge Woodmen's common bond and purpose.

Applications for New Certificate:

Except for coverage which may be provided in the RECEIPT AND CONDITIONAL INSURANCE AGREEMENT, no insurance will be in force because of this application until it has been approved and at least one monthly premium has been paid to Woodmen.

Applications for Reinstatement or Change to Existing Certificate:

I agree this application shall not be construed as extending temporary insurance coverage on the life of any proposed insured. Reinstatement of or change to existing insurance will be effective and coverage will commence on the date this application is approved in the Home Office of Woodmen.

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.

19 ACKNOWLEDGEMENT AND AGREEMENT, Continued

Proposed Primary Insured

Certification Instructions - You must cross out the language in item **(2)** within this box if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on a tax return.

Under penalties of perjury, I, the undersigned, certify:

(1) the number(s) shown on this application represents my correct Taxpayer Identification Number (TIN) AND

(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, AND

(3) I am a United States person (including a United States resident alien).

Proposed Other Insured

Certification Instructions - You must cross out the language in item **(2)** within this box if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on a tax return.

Under penalties of perjury, I, the undersigned, certify:

(1) the number(s) shown on this application represents my correct Taxpayer Identification Number (TIN) AND

(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, AND

(3) I am a United States person (including a United States resident alien).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed at _____
City State

☐ **By checking this box, I, the proposed applicant(s), acknowledge this application was signed in a different state than the state in which I reside.**

_____ _____ _____ _____
Signature of Proposed Primary Insured/Applicant | Date | Signature of Proposed Other Insured/Applicant | Date

_____ _____ _____ _____
Signature of Witness | Date | Additional Witness if Required | Date

20 FIELD REPRESENTATIVE'S CERTIFICATION

1. Were you present when this application was signed? (If "No", submit a full explanation with the application) . . . ☐ Yes ☐ No
2. Does either proposed applicant have any existing life insurance or annuity contracts? . . . . . ☐ Yes ☐ No
3. Do you have knowledge or reason to believe that replacement of existing insurance or annuities for either applicant was or may be involved? (If "Yes", submit replacement forms, if required) . . . . . ☐ Yes ☐ No

_____ _____ _____
Signature of Field Representative | Date | Field Representative's Name Printed