

WESTERN CATHOLIC UNION, A Fraternal Benefit Society
APPLICATION SUPPLEMENT

Supplement to a life insurance application dated: _____ for: _____ Proposed Insured.

Complete applicable parts of Part A. Complete part B.

A. Payor, Waiver of Premium Benefit Rider; Form: _____

Female
 Male

Payor, name: _____
 Date of Birth: _____ Height: _____ Weight: _____ Occupation: _____
 Relationship to Proposed Insured: _____
 Address (if different from that shown in the application): _____

Children's Insurance Rider, Level Term Life Insurance; Form: R-CR-03
 Benefit Amount: _____ (Minimum - \$1,000, Maximum - \$10,000)
 Children: Age 16 days through Age 17. (If additional space is needed, use separate sheet, dated and signed.)

Name and Relationship to Proposed Insured	Gender	Date of Birth	Height	Weight	Insurance In Force
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Proposed Insured (Applicant if other than Proposed Insured), Insurance in Force: _____

Spouse Insurance Rider, Decreasing Term Life Insurance; Form: R-SR-03
 Issue Ages: 18 through 59, near birthday. Minimum Issue: 1 Unit.
 Death Benefit, per Unit: through age 39, \$7,500; 40-49, \$5,000; 50-59, \$2,500; 60-65, \$1,000.

Female
 Male

Spouse, name: _____
 Date of Birth: _____ Height: _____ Weight: _____ Occupation: _____
 Death Benefit, Number of Units: _____

- B. 1. In the past 5 years, has any person named in Part A above: (1) been diagnosed by a physician as having any disease or disorder; or (2) been confined in a medical care facility or had such confinement recommended: No. Yes.
 2. Is any person named in Part A above currently using medication prescribed by a physician: No. Yes.
 3. Does any person named in Part A above have an existing physical deformity or impairment: No. Yes.

Details, any Yes answer to the above questions, show: condition; date and duration; medication; and, name and address for all physicians and any medical care facilities. If more space is needed, use a separate sheet, dated and signed.

Each person signing this Application Supplement **REPRESENTS** that, to the best of such person's knowledge and belief, all statements and answers included herein are complete, true and accurately recorded.

AUTHORIZATION. The undersigned hereby authorize any physician or medical care facility that may have any records or information regarding the undersigned, or the minor children of the Proposed Insured, to provide such information to the Western Catholic Union. Any information obtained will: (1) be used to determine eligibility for insurance or benefits; and (2) be treated as confidential and released only as may be lawfully required. This Authorization shall be valid for a period of 24 months from the date shown below. This Authorization may, in writing, be revoked at any time prior to expiry. A photocopy shall be valid as the original.

Signed at _____ this _____ day of _____, 20____

_____ Proposed Insured	_____ Payor, if Payor Benefits applied for
_____ Witness, licensed agent where required	_____ Spouse, if Spouse Benefits applied for
	_____ Owner, if other than Proposed Insured