

**APPLICATION FOR INSURANCE**  
**THE MOST EXCELLENT ASSEMBLY OF THE**  
**ARTISANS ORDER OF MUTUAL PROTECTION**  
*(A Fraternal Benefit Society)*  
 8100 Roosevelt Blvd.  
 Philadelphia, PA 19152-2911  
 (215) 708-1000; FAX (215) 708-1779

**USE THIS FORM FOR  
THE FOLLOWING AMOUNTS:**

Age	Amounts Under
0 - 50	\$5,001
51 - 65	3,001
66 - 70	1,001
	OR
Juv. Term	\$25,001

Is applicant a member of The Artisans Order of Mutual Protection? Yes ( ) No ( )  
 If not, apply for membership. Assembly: \_\_\_\_\_

1. Full name (print): \_\_\_\_\_ Telephone: \_\_\_\_\_
2. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
3. Birthdate; Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_; Birthplace: \_\_\_\_\_
4. Sex: ( ) M ( ) F; Social Security No.: \_\_\_\_\_; Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.; Weight: \_\_\_\_\_ lbs.
- 5a. Do you now use tobacco? ( ) Yes. ( ) No. If yes, explain (type): \_\_\_\_\_
- 5b. Ever used tobacco? ( ) Yes. ( ) No. If yes, explain (type, date quit): \_\_\_\_\_
- 6a. Occupation: \_\_\_\_\_ 6b. Employer: \_\_\_\_\_
- 7a. Name and Address of Beneficiary: \_\_\_\_\_  
 \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_
- 7b. Contingent Beneficiary: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_  
 Address: \_\_\_\_\_
- 7c. Owner, if other than proposed insured: \_\_\_\_\_ Relationship? \_\_\_\_\_
8. Is this insurance intended to replace or change any Insurance or Annuity now in force? ( ) Yes. ( ) No.  
 If yes, give details: \_\_\_\_\_
- 9a. Within last 5 years, has Proposed Insured been hospitalized; or received medical treatment or advice for any illness; disease; injury; or physical condition? ( ) Yes. ( ) No.
- 9b. Does Proposed Insured have any physical or mental handicaps? ( ) Yes. ( ) No.
- 9c. Give details of YES answers to 9(a) and 9(b). (Illness or handicap; dates; duration; physicians; and/or hospital): \_\_\_\_\_

10. Plan of Insurance: \_\_\_\_\_; Amount of Insurance: \$ \_\_\_\_\_  
 Rider/s: \_\_\_\_\_; Premium: \$ \_\_\_\_\_  
 Method of Payment: [ ] Single Premium; [ ] Annual; [ ] Semi-Annual; [ ] Quarterly.
11. Do you as applicant declare that you have read each of the above answers and that to the best of your knowledge and belief, they are full, complete and true? ( ) Yes. ( ) No.

**I AGREE THAT NO INSURANCE SHALL TAKE EFFECT UNLESS AND UNTIL: (1) the first premium shall have been paid; (2) a certificate is delivered to the applicant during the Proposed Insured's lifetime; (3) the health of the Proposed Insured is as described in the application; (4) the Proposed Insured has been obligated in due form; and (5) all requirements of the Constitution and By-laws have been complied with.**

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_

\_\_\_\_\_  
 Signature of Agent or Proposer                      Proposed Insured's Signature                      Adult Applicant's Signature (Parent or Guardian if applicant is under age 16.)

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**AUTHORIZATION**

I hereby authorize any licensed physician; medical practitioner; hospital; clinic; or other medical; or medically related facility; insurance company; the Medical Information Bureau; or other organization; institution; or person, that has any records or knowledge of me or my health, to give to the Artisans Order of Mutual Protection, or its representatives, including Equifax; or bearer; or reinsurer, any such information. This authorization is valid for no longer than 30 months. A photographic copy of this authorization shall be as valid as the original.

Date \_\_\_\_\_, 19 \_\_\_\_\_  
 \_\_\_\_\_  
 Proposed Insured's Signature

\_\_\_\_\_  
 Signature of Agent or Proposer                      Adult Applicant's Signature (if proposed insured is under age 16.)

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See Notices on Reverse Side.

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### **Pennsylvania Fraud Warning Notice**

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

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### **New Jersey Fraud Warning Notice**

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

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### **NOTICE OF THE FAIR CREDIT REPORTING ACT**

In compliance with Federal Laws known as the Fair Credit Reporting Act, this notice is to inform you that, as part of our normal Underwriting procedures, in connection with an application for insurance or the insurance which you now have in force:

1. An investigative consumer report, prepared as you have authorized, may be made; whereby information is obtained through personal interviews with your neighbors; friends; or others with whom you are acquainted. This inquiry will include information as to: character; general reputation; personal characteristics and mode of living; with respect to: you; members of your family; and others having an interest in; or closely connected with the insurance transaction; and
2. Upon your written request, made within a reasonable time after you receive this notice, additional information as to the nature and scope of the investigation, if one is made, will be provided.

We also, if a consumer report has been requested, will provide you with the name and address of the consumer reporting agency to whom the report was made. You may receive a copy of the report, in accordance with the statutes of your state of residence, by contracting the consumer reporting agency directly. Requests for additional information should be addressed to: the Artisans Order of Mutual Protection, 8100 Roosevelt Blvd., Philadelphia, PA 19152-2911 .

### **PRE-NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (MIB)**

Information provided regarding your insurability will be treated as confidential. The Artisans Order of Mutual Protection may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange in behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage, or to which a claim is submitted, the MIB will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contract the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone number: (617) 426-3660.

The Artisans Order of Mutual Protection or its reinsurers may also release information in its files to: reinsurers; or to other life insurance companies to whom you may apply for life or health insurance; or to whom a claim for benefits may be submitted.