

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

Part One of
Application
PLEASE PRINT

A. IDENTIFICATION OF PROPOSED INSURED

Is applicant a member of the Artisans Order of Mutual Protection? Yes () No ().
 If not, apply for membership.

Agent Contract #: _____

1a. Full Name of Proposed Insured: _____ 1b. Social Security No: _____

2. Address: _____ City: _____ State: _____ Zip Code: _____

3a. Birth date: (Month, Day, Year) _____ b. Age: _____ c. Birthplace: _____ 4. () Male
 () Female

5. Name of Employer: _____ 6. Address: _____

7a. Occupation: _____ b. How long employed, Years: _____ Months: _____

B. THE INSURANCE

1. Basic Plan: _____ 2. Amount of Insurance: _____

3. Riders with this Plan:
 a. () Accidental Death Benefit; Amount: \$ _____
 b. () Payor/Waiver of Premium; Initial Premium: \$ _____ Benefits Commence at Age: _____
 c. () Flexible Premium Annuity Rider;
 d. () Yearly Renewable Term Rider
 e. () Other: _____ Amount: \$ _____

4. Premium to be paid: () Monthly; () Quarterly; () Semi-Annual; () Annual. 5. Automatic Premium Loan: () Yes () No.

6. Send correspondence to Proposed Insured's:
 () Residence; () Business; () Other _____; () or to Policy Owner.

7. Amount Paid with Application: \$ _____. Dividend Options: () Purchase Dividend Additions; () Paid in Cash
 () Dividend Accumulations (Must have SS#, See 1b)

9. Beneficiary. Will receive proceeds unless changed by the Owner. (List full name, relationship, and birth date.)

NAME	RELATIONSHIP	BIRTH DATE	AMOUNT
			\$ _____
			\$ _____

10. Contingent Beneficiary. If any: (list full name and address.) _____

C. INSURABILITY

<p>1. Has a Health Care Provider treated or diagnosed the proposed insured for any disease or disorder of: (If yes, circle condition and give details in No. 4.)</p> <p>a. Nervous system; epilepsy; or paralysis? Arthritis or any disease of the joints; back; or spine? () Yes () No.</p> <p>b. The heart or blood vessels; chest pains; high or low blood pressure; rheumatic fever? () Yes () No.</p> <p>c. Stomach; liver; intestines; gall bladder? () Yes () No.</p> <p>d. The kidney; urinary; bladder; prostate? () Yes () No.</p> <p>e. Lungs; asthma; tuberculosis? () Yes () No.</p>	<p>2. Has Proposed Insured been treated for or advised, by a Health Care Provider, of: (If yes, circle condition and give details in No. 4.)</p> <p>a. Cancer; tumor; diabetes; gout; glands; or blood disorders? () Yes () No.</p> <p>b. Any illness; disease; condition; or injury; or deformity not already listed. () Yes () No.</p> <p>c. Consultation, treatment or been examined by a physician or other practitioner for any other reason? () Yes () No.</p> <p>d. Any current medication? () Yes () No.</p>
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3. Height and weight of Proposed Insured: _____ ft. _____ in.; _____ lbs.

4. Give complete details of any "YES" answers to Questions C1 and 2. Give the full name and addresses of physicians seen or hospitals used within the last 5 years. Include dates, nature of disease, or injury and treatment.

5a.

Family Record	Living		Dead	
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers/Sisters				

5b. Have any of your parents, brothers, or sisters ever had heart disease, diabetes, or mental illness? () Yes () No.
 If yes, explain: _____

6. In the past 5 years, have you:
 a. used alcoholic beverages? () Yes () No. Details of Yes Answer: _____
 b. used narcotics or drugs (not prescribed by a physician)? () Yes () No.

7. In the past 10 years, have you been treated for alcoholism or any drug habit? () Yes () No. If yes, explain: _____

8. In the past 10 years, have you been in a hospital; clinic; sanatorium; or institution for examination; observations; diagnosis; operation; or treatment? () Yes () No. If yes, explain: _____

