THE SUPREME COUNCIL OF THE ROYAL ARCANUM

61 Batterymarch Street, Boston, MA 02110
1-888-272-2686

APPLICATION FOR
FINAL EXPENSE
SIMPLIFIED WHOLE LIFE

Amount Collected: $50.00 Agent #: 11111B

Please Print all Answers. Do not use white out. All corrections must be initialed by Applicant.

Is Adult Applicant a Member? No Council Name and Number:_____ or
Applicant hereby applies for membership.

APPLICANT INFORMATION

John R. Sample — First Name, Initial, Last Name of Proposed Insured
000-00-0000 — Social Security Number

05 20 1964 — Month Day Year Date of Birth
Male Female — Sex
N/A — Maiden Name

New York, U.S. — Place of Birth (State or Country)
car salesman — Occupation
(914) 000-0000 — Residence Phone

99 Franklin St. — Residence Address (street or Route & Box #)
Buffalo — City
NY — State/Providence
00000 — Zip Code

Amount of Insurance: $25,000
Accidental Death Benefit: $25,000
Send Premium Notices to: Insured ____ Owner ✓

Automatic Premium Loan elected? Yes ✓ No ___

Premiums $50.00 — Annual ___ Semi-Annual ___ Quarterly ___ Check-o-Matic ✓

Is this insurance intended to replace any exiting insurance or annuities? Yes ____ No ✓
(If "yes," give company name, address & policy number)
Have you used tobacco in any form in the past 12 months? Yes ____ No ✓
What is your height? 5 ft 10 In. What is your weight? 160 lbs.

Owner Information (If Other Than Proposed Insured) Same as Insured

First Name, Initial, Last Name — Relationship and Social Security Number

Residence Address (Street or Route & Box #) — City — State/Providence — Zip Code

PRIMARY BENEFICIARY SECTION

First Name, Initial, Last Name	Relationship to Proposed Insured		Share %
Marie M. Sample	wife	SS# 000-00-000	100%

CONTINGENT BENEFICARY SECTION

First Name, Initial, Last Name	Relationship to Proposed Insured		Share %
Robert L. Sample	Son	SS# 000-00-0000	50%
Linda A. Sample-Jones	Daughter	SS# 000-00-0000	50%

MEDICAL INFORMATION SECTION

IF ANY ANSWER TO QUESTION 2 THROUGH 7 IS "YES", YOU ARE NOT ELIGIBLE FOR COVERAGE

	YES	NO
Are you currently hospitalized or have you been hospitalized in the past two years? If yes, explain. (Attach additional sheet if necessary):_____	____	✓
Are you currently confined to a nursing facility or have you been confined to a nursing facility in the past (6) months?	____	✓
In the past two years, have you been diagnosed, received medical advice, received treatment, or taken medication for mental or nervous disorder, neurological disorder, cancer, liver disease, alcohol or drug abuse, heart attack, heart or circulatory disease, cerebrovascular disease, stroke, kidney disease, emphysema, chronic obstructive pulmonary disease or diabetes requiring the use of insulin treatment?	____	✓
In the past two years, have you had surgery for an organ or tissue transplant?	____	✓
In the past year, have you been advised to have surgery, hospital or nursing facility confinement, and have not done so?	____	✓
Have you ever been diagnosed by a physician as having, or been tested positive for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	____	✓
Have you been postponed or rejected for insurance in the past two years due to medical reasons?	____	✓

Agreement Declaration

THE APPLICATION - Each person signing below agrees that: (1) to the best of his/her knowledge and belief, all statements made in this application and any supplements are complete and true and were correctly recorded; this application and any supplements shall for the basis for and become part of any policy issued; and (3) he/she adopts all statements in the application and agrees to be bound by them. Each person agrees that the Charter, Constitution and Laws of the Supreme Council of the Royal Arcanum now in effect or hereafter enacted shall be binding upon them and their beneficiary.

LIABILITY OF THE SOCIETY - The Society shall have no liability unless (1) the application has been approved by the Society at its Home Office; (2) the first premium has been paid during the lifetime of the proposed insured; (3) the policy has been delivered to the person named as Owner in the policy; and (4) at time of payment and delivery all statements in the application are complete and true as though they were made at that time. If any of these conditions are not met, the insurance applied for shall not take effect.

AUTHORITY OF AGENTS - No Agent of the Society can change the terms of this application. No agent can change any policy issued by the Society. No agent can waive any of the Society's rights or requirements. No Agent can extend the time for any premium payment.

CHANGES AND CORRECTIONS - Any changes or corrections of the application will be made in the "Home Office Endorsements" section of the policy for or on an Amendment of application attached to the policy. Acceptance of any policy issued shall be acceptance of any changes or corrections made by the Society.

ACKNOWLEDGMENT - I (we) have received a notice concerning the "Medical Information Bureau".

Authorization - For a period not to exceed 24 months from the date of this Application, I (we) authorize the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of the proposed insured to give such information to The Supreme Council of the Royal Arcanum or its re-insurer. A photographic copy of this authorization shall be as valid as the original.

Dated at Buffalo, NY _____ Signature of Proposed Member/Proposed Insured

(City or Town, State/Providence)

this 13th day of May, 20 15

_____ Signature of Owner if other than Proposed Insured

I certify that the information has been accurately recorded: _____ Signature of Agent

Insured sign

Owner Sign

Agent Sign

Receipt

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE SUPREME COUNCIL OF THE ROYAL ARCANUM. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.

Received from John R. Sample "You") this 13th day of May _____, 20 15, the sum of $ 50.00 _____

The supreme Council of the Royal Arcanum ("Society") accepts this payment of the first premium in connection with a life application ("the Application") having the same date. The Society shall have no liability unless: (1) the application has been approved by the Society at its Home office; (2) the first premium has been paid during the lifetime if the Proposed Insured; (3) the policy has been delivered to the person named as Owner in the policy; (4) at time of payment and delivery all statements in the application are complete and true as though they were made at that time. If any of these conditions are not met, the insurance applied for shall not take effect. Each person agrees that the Charter, Constitution and Laws of the Supreme Council of the Royal Arcanum now in effect or hereafter enacted shall be binding upon them and their beneficiary.

MEDICAL INFORMATION BUREAU NOTICE

Information regarding your insurability will be treated as confidential. The Society or its re-insurer (s) may, however, make a brief report there on to the Medical Information Bureau. The Bureau is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or claim for benefits is submitted to a company, the Bureau, upon request, will supply such company information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set fourth 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 Supreme Council of the Royal Arcanum or its re-insurer (s) may also release information in its file 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.

The Supreme Council of the Royal Arcanum, 61 Batterymarch Street, Boston, MA 02110
Telephone number: 1-888-272-2686

Agent sign

Owner Sign

Signature of Agent

Signature of Proposed Member/Proposed Insured

FOUNDED
BOSTON
1877

BENEFITS PAID
OVER
$ 469,701,000

SUPREME COUNCIL
OF THE
ROYAL ARCANUM

AN INTERNATIONAL FRATERNITY — PROVIDING FAMILY PROTECTION

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

(1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated? Yes____ No ✓

(2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of non-forfeiture benefit; or otherwise reduced in value by the use of a non-forfeiture benefit, dividend accumulations, dividend cash values or other cash value? Yes____ No ✓

(3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force? Yes____ No ✓

(4) Reissued with a reduction in amount such that any cash values are released, including all transactions where dividend accumulations or paid-up additions are released on one or more of the existing policies? Yes____ No ✓

(5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or within on one or more existing policies? Yes____ No ✓

(6) Continued with a stoppage of premium payments or reduction in the amount of premium paid? Yes____ No ✓

If you have answered yes to any of the above questions, a replacement as defined by New York insurance department regulation number 60 has occurred or is likely to occur and your agent is required to provide you with a completed "Disclosure Statement: and the "Important notice regarding replacement or change of life insurance policies or annuity contracts".

APPLICANT

DATE:_____ **SIGNATURE OF APPLICANT:**_____

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION:
YES_____ **NO** ✓

AGENT

DATE:_____ **SIGNATURE OFAGENT:**_____

61 BATTERYMARCH STREET, BOSTON MA 02110
TOLL FREE 1-888-272-2686 TEL. 617-426-4135 FAX 617-412-4609
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SUPREME COUNCIL
OF THE
ROYAL ARCANUM
AN INTERNATIONAL FRATERNITY — PROVIDING FAMILY PROTECTION

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

John R. Sample

Proposed Insured's Name: _____

Date of Birth 05/20/1964 **SSN:** 000-00-0000

Authorization: I (we) authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medical related facility, health care provider or any mental health care provider, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or any family members proposed for coverage, to give such information to the **Supreme Council of the Royal Arcanum** or its re-insurer.

The information to be disclosed is: my full, complete and entire medical record, all information and data in your possession, under your control or that you have access to. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or ARC and my past medical history.

Term of this Release: I understand this authorization will expire, without my express revocation, thirty (30) months from the date of signing.

Revocation of Authorization: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization.

Disclosed Records, Information and Data may not be Protected: I understand that the Heath Insurance Portability and Accountability Act of 1996 (HIPAA), HIPAA regulations as well as other Federal and State laws and regulations, create a right of privacy that is associated with the records, information and data covered by this release. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rule.

Photographic Copy: A photographic copy of this authorization shall be as valid as the original.

Receipt: I/We acknowledge receipt of a true and correct copy of this completed form.

_____ Date — _____ Signature of Proposed Insured or Authorized Personal Representative

SIGN HERE

_____ Date — _____ Signature of Parent and/or Sponsor

_____ Date — _____ Print Name and Relationship of Personal Representative/Sponsor

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Supreme Council of the Royal Arcanum
61 Batterymarch Street
Boston, MA 02110
1-888-Arcanum (1-888-272-2686)
Addendum to Application Forms

Notice of Information Practices.

The application form will be the major source of information about you used to underwrite your application for insurance. The Society may also: (a) collect or verify information from other sources; and (b) ask a consumer reporting agency to collect information and submit a report to us. Consumer reports are a usual part of the process of evaluating risks for life and health insurance.

You may request in writing to be informed as to whether a consumer report was prepared. The name and address of the reporting agency that prepared any report will be given to you. You may obtain a copy of the report from that agency. If information from a consumer report has an adverse effect on our underwriting decision, the Society will notify you. The Society will also furnish the name and address of the reporting agency. You may discuss the matter with that agency if you wish.

Information regarding your insurability will be treated as confidential. The Society or its reinsurers may, however, make a brief report to the MIB, Inc., formerly known as the Medical Information Bureau. The MIB is a non-profit membership organization of insurance companies. The MIB 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 in its file.

On receipt of a request from you, the MIB will arrange disclosure of any information it has in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of the information in the 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 MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The Society or its reinsurers may also release information in its files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about the MIB may be obtained on its web site at www.mib.com.

You have the right of access to certain items of information the Society has collected about you. You also have the right to request a correction of any information you feel is inaccurate. In the event of an adverse underwriting decision, the Society will either (a) provide you with the specific reason for the adverse underwriting decision in writing, or (b) advise you that upon written request, you have the right to receive the specific reason in writing.

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.

If you wish to have a more detailed description of the Society's information practices, send a written request to the Society's Home Office at the address shown above.

PROPOSED INSURED/ANNUITANT/OWNER STATEMENT

I declare that the statements and answers given in this addendum to the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that this addendum to the application shall be included as part of the basis for and a part of any contract issued by the Supreme Council of the Royal Arcanum. I understand that the Supreme Council of the Royal Arcanum may disclose information about the person to be insured to the MIB. I have received the Notice of Information Practices; it explains my rights under the Fair Credit Reporting Act as it pertains to consumer reports and the MIB.

_____ _____

Signature of Proposed/Insured/Annuitant/Owner Date Signed

SAMPLE

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OVER
$ 469,701,000

SUPREME COUNCIL
OF THE
ROYAL ARCANUM

AN INTERNATIONAL FRATERNITY

PROVIDING FAMILY PROTECTION

STATEMENT OF UNDERSTANDING

I have not received a copy of the illustration conforming to the certificate for which I have applied. I Understand that an illustration conforming to the certificate as issued will be provided to me no later than the time of certificate delivery.

Signature of John Sample	05/21/2015
Applicant's Signature	**Date**

APPLICANT

John Sample	000-00-0000
Applicant's Name (printed)	**Social Security Number**

No illustration was presented to the applicant at the time of the application was completed. An Illustration conforming to the certificate as issued will be provided no later than the time of delivery.

Agent's signature	05/21/2015
Agent's Signature	**Date**

AGENT

This form must be attached to the application.

ILL-1

61 BATTERYMARCH STREET, BOSTON MA 02110
TOLL FREE 1-888-272-2686 TEL. 617-426-4135 FAX 617-426-2322
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SUPREME COUNCIL
OF THE
ROYAL ARCANUM

AN INTERNATIONAL FRATERNITY — PROVIDING FAMILY PROTECTION

BENEFITS PAID
OVER
$ 420,904,000

61 BATTERYMARCH STREET, BOSTON, MA 02110
TOLL FREE 1-888-272-2686 TEL. 617-426-4135 FAX 617-426-2322
www.royalarcanum.com

Yes, I want to enroll in ***CHECK-O-MATIC,*** and on my scheduled payment date have the Royal Arcanum deduct my payment automatically from the account indicated on the enclosed check.

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS

Please sign and return with your payment. Be sure to use the checking account which you want to be debited for the ***CHECK-O-MATIC*** option.

If payment isn't due and you want to setup ***CHECK-O-MATIC*** for your next payment please send in a voided check from the account you want debited.

Please **circle** the mode of payment and date the withdrawal is to be made.
Monthly * / Quarterly / Semi-Annual / Annual, 1st, 5th or 15th of the Month.
*** Monthly payments are only permitted through *CHECK-O-MATIC*.**

I hereby authorize Royal Arcanum, to initiate debit entries to my Checking account indicated by the enclosed check. This authorization is to remain in full force and effect until Royal Arcanum has received written notification from me of its termination in such time and in such manner as to afford Royal Arcanum and Depository a reasonable opportunity to act on it.

NAME John Sample DATE 05/15/2015
(Please Print Clearly)

BANK NAME Federal Credit Union CHECKING ✓ SAVINGS

BANK ROUTING NUMBER 000000000 ACCOUNT NUMBER 123123123

N/A home office use

CERT NO. _____ SIGNATURE _____

(Payor's signature)

PLEASE ATTACH YOUR VOIDED CHECK HERE

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SUPREME COUNCIL
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ROYAL ARCANUM

AN INTERNATIONAL FRATERNITY — PROVIDING FAMILY PROTECTION

CREDIT CARD AUTHORIZATION FORM

Please answer all questions completely.

Cardholder's name: John Sample Tel: (914) 000-0000

Billing Address: 99 Summer St.
Street

Anywhere, NY 00000
City State Zip Code

✓ VISA
☐ MASTERCARD

Card Number 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

Expiration Date: 09/2016

Please charge my credit card on a:

		Date of Debit:
✓ Monthly basis	J.S. (Initials)	06/25/2015
☐ Quarterly basis	_____ (Initials)	_____
☐ Semi-annual basis	_____ (Initials)	_____
☐ Annual basis	_____ (Initials)	_____

By signing below, I authorize Visa or MasterCard to periodically bill the appropriate premium on my statement and to automatically renew my insurance unless cancelled in writing by me or by The Supreme Council of Royal Arcanum.

Card Holder's Name (PLEASE PRINT): John Sample

Card Holder's Signature: _____

Sign Here

Date: _____

For office use only

Policy #: _____ Name of Insured: _____
Additional Policy: _____ : _____

Amount to be charged: _____

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