FOUNDED
BOSTON
1877

BENEFITS PAID
OVER
$ 469,701,000

SUPREME COUNCIL
OF THE
ROYAL ARCANUM
AN INTERNATIONAL FRATERNITY
PROVIDING FAMILY PROTECTION

New Business Cover Sheet

Must be completed and sent in with every application

To: New Business Attn: _____ **Fax (617) 426-2322**

Re proposed Insured: _____ Plan: _____
Print clearly or type

Agent Name: _____ Date: _____ Pages _____
Print clearly or type

Agent code for L&A_____ Agent code for Graded _____

Agent Email: _____ Agent Tel. # _____

Comments:

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

THE SUPREME COUNCIL OF THE ROYAL ARCANUM

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

A FRATERNAL BENEFIT SOCIETY

APPLICATION FOR LIFE INSURANCE – GRADED BENEFIT WHOLE LIFE PLAN

Application for Individual Life Insurance to the Supreme Council of the Royal Arcanum

Amount Collected $ _____ Agent # _____

Is Applicant a Member? ☐ Yes; Council Name and #: _____ ☐ No; Applicant hereby applies for membership.

A. Proposed Insured

1. Name in Full (First, Middle, Last) _____ ☐Male ☐Female
2. Address _____
   City _____ State _____ Zip Code _____
3. Social Security #_____ 4. Phone (Day) _____ (Evening) _____
5. Date of Birth _____ 6. Maiden Name_____
7. Place of Birth: City_____ State _____
8. E-mail Address _____

B. Prior Residence of Proposed Insured (If less than 3 years at current address)

Address_____

City _____ State _____ Zip Code _____

C. Amount Applied For

Face Amount: $_____

D. Premiums and Dividends

Premiums: ☐ Annually ☐ Semi-annually ☐ Quarterly ☐ Monthly (Monthly available only with check-o-matic or credit card)

Issue with Automatic Premium Loan Option? ☐ Yes ☐ No

Dividend Options: ☐ Cash ☐ Paid-Up Additions ☐ Left at Interest ☐ Reduce Premium

E. Beneficiaries (List additional beneficiaries on a separate sheet of paper):

Primary Beneficiary	Relationship to Insured	Address	Social Security #	Share %
1.				
2.				
3.				

Contingent Beneficiary	Relationship to Insured	Address	Social Security #	Share %
1.				
2.				
3.				

F. Owner Information – If other than Proposed Insured. All notices will be sent to the Owner unless otherwise specified.

Name in Full of Owner: _____ E-mail Address _____

Address of Owner: _____

City _____ State _____ Zip Code _____

Owner Social Security #_____ Date of Birth_____ Relationship to Proposed Insured_____

G. Secondary Addressee (Optional) – This person will receive copies of overdue premiums and lapse notices.

Name: _____

Mailing Address: _____

City _____ State _____ Zip Code _____

H. Insurance in Force and Applied for: (If none, so state) Do not include this application.

	Year Issued	Company	Amount	Plan
1.				
2.				
3.				

I. Medical Information

If any answer is "Yes", then you are not eligible for coverage.

	Yes	No	
1.	☐	☐	Are you currently confined to a bed, or in a hospital, clinic, rest or convalescent home?
2.	☐	☐	Have you ever been diagnosed or treated by a licensed medical doctor for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

J. Replacement of Insurance - Will the insurance applied for replace or change any existing insurance or annuity contracts with the Royal Arcanum or any other company or fraternal benefit society? ☐ Yes ☐ No.

If yes, show the name of Company and Policy Number(s); add an additional sheet of paper, if necessary. A state replacement form must be completed should there be a replacement or potential replacement because of the new coverage.

_____

_____

_____

K. Agreement Declaration

Each of the undersigned certify that we have read the completed application. We, the undersigned, agree to the following:

1. All answers and statements in this application are true and complete to the best of our knowledge and belief. The Supreme Council of the Royal Arcanum ("the Society") will rely on the answers and statements in the application as the basis for any policy issued. I, the applicant, understand that no coverage will be issued if the age of the Proposed Insured or the face amount applied for do not meet the underwriting standards that apply to this policy.
2. Coverage under the policy will become effective only if and when (a) the first premium has been paid during the lifetime of the Proposed Insured, (b) the Society has been notified of any change since the date of the application in the health of the Proposed Insured, and (c) the policy is delivered and all delivery requirements are fulfilled during the lifetime of the Proposed Insured.
3. If there is a change in the Proposed Insured's health before a policy is delivered, and the change will alter any statement or answer to any question in the application, the applicant or the Proposed Insured will immediately notify the Society. If the Proposed Insured is not eligible for the insurance applied for, no policy of any kind will be in effect.
4. The Charter, Constitution and Laws of the Society now in effect or hereafter enacted shall be binding upon them and their beneficiary.
5. If the Monthly premium mode is selected, the applicant authorizes premiums due to be automatically paid to the Society

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 or any policy issued by the Society. No agent can waive any of the Society's rights or requirements, or extend the time for any premium payment.

CHANGES AND CORRECTIONS- Any changes or corrections to the application will be made in an Amendment to the application and attached to the policy. Acceptance of any policy issued shall be acceptance of any changes or corrections made by the Society.

INSURANCE FRAUD WARNING NOTICE

The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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; (2) this application and any supplements shall form the basis for and become part of any policy issued by the Society; (3) no information about the Proposed Insured will be considered to have been given to the Society unless it is stated in the application, and (4) they will notify the Society of any changes in the statements or answers given in the application between the time of the application and the delivery of the policy. 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.

Dated at_____ this _____day of _____, 20_____
(City or Town, State/Province)

_____ _____
Signature of Applicant/Owner/Proposed Insured Age 18 and over Signature of Applicant/Owner if other than Proposed Insured

---

Agent Statement and Report

	Yes	No	
1.	☐	☐	Did you personally see the Proposed Insured at the time this application was written? (If no, explain). _____
2.	☐	☐	Will the insurance being applied for replace or change any existing life insurance or annuities in this or any other company? If "yes", has a replacement form been completed? (Attach replacement form to application along with any proposals used).
3.	☐	☐	Was a receipt issued?
4.	☐	☐	Did you give the Applicant a Buyer's Guide?
5.	☐	☐	Did you give the Applicant an Illustration?
6.	☐	☐	Is the Proposed Insured presently confined to a bed, in a hospital, clinic or nursing, rest or convalescent home?
7.	☐	☐	Have you been informed, or are you aware, that the Proposed Insured has been diagnosed or treated by a licensed medical doctor for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

I certify that the information has been accurately recorded. I have no knowledge of anything affecting the Insurability of the Proposed Insured that is not fully set forth in these papers.

_____ _____
Signature of Agent-Service Specialist Date

_____ _____
Name of Agent-Service Specialist Name of Recommender

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 _____("You") this _____ day of _____, 20___, the sum

of $_____.

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 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. 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.

_____ _____

Signature of Agent Print Name of Agent

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, LLC., formerly known as the Medical Information Bureau. 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. 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

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SUPREME COUNCIL OF THE ROYAL ARCANUM

AN INTERNATIONAL FRATERNITY PROVIDING FAMILY PROTECTION

BENEFITS PAID
OVER
$420,904,000

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.

_____ _____
Applicant's Signature **Date**

_____ _____
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 **Date**

This form must be attached to the application.

ILL-1

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A FRATERNAL BENEFIT SOCIETY

PAYMENT AUTHORIZATION FORM

Proposed Insured: _____ Policy Number, if known: _____

Complete this form only when authorizing a bank account withdrawal for premium payment.

PAYMENT INFORMATION

1. **Initial Monthly Premium Payment (select only one option)** Premium Amount Quoted $_____

   ☐ Draft premium immediately upon issue/approval.

   ☐ Draft initial premium on or after: _____/_____/_____

   NOTE: If policy issue is after date selected, premium will be withdrawn on the policy issue date or receipt of delivery requirements.

   ☐ Check collected and mailed to the Supreme Council of the Royal Arcanum

   When choosing automatic bank account withdrawal, money will be withdrawn from your account as stated above. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first ongoing withdrawal may exceed on modal premium and may occur on a date other than the policy date. The Supreme Council of the Royal Arcanum cannot establish electronic payments from foreign banks.

2. **Ongoing Premium Payments** – Automated Bank Account Withdrawal (Monthly)
   Specify the date ongoing premiums will be withdrawn: (either 1st, 5th, 15th, or 20th of each month) _____
   Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the selected date above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

PAYOR INFORMATION

Name of payor as shown on the bank account: _____ Social Security Number _____

ACCOUNT INFORMATION

1. Account Type (check one) ☐ Checking ☐ Savings
2. Name of Financial Institution: _____
3. Complete information below or attach a voided check

   Bank Routing Number: _____ Bank Account Number: _____

AUTHORIZATION

I authorize the Supreme Council of the Royal Arcanum (the Society) to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. I authorize my financial institution to pay from my account to the Society any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the Society in writing of any changes in my account information. This authorization will be effective until I give my financial institution at least three business days' notice to cancel. If notice is given verbally, the Society may require written confirmation from me within 14 days of my verbal notice.

Date: _____ _____
Mo./Day/Yr. Authorized Signature as Shown on Account

SUPREME COUNCIL
OF THE
ROYAL ARCANUM
AN INTERNATIONAL FRATERNITY — PROVIDING FAMILY PROTECTION

CREDIT CARD AUTHORIZATION FORM

Please answer all questions completely.

Cardholder's name: _____ Tel: _____

Address: _____
Street City State Zip Code

☐ VISA
☐ MASTERCARD

Card Number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: _____

Policy #: _____ Name of Insured: _____

Amount to be charged: _____

Please charge my credit card on a:		Date of Debit:
☐ Monthly basis	_____ (Initials)	_____
☐ Quarterly basis	_____ (Initials)	_____
☐ Semi-annual basis	_____ (Initials)	_____
☐ Annual basis	_____ (Initials)	_____

By signing below, I authorize Royal Arcanum to debit my Visa or Master Card for the initial premium once my application has been approved by underwriting. I understand that the debit date elected above will be used for the initial premium as well as recurring premiums.

*Please note: For **new business** the initial debit date must be **within 30 days** from the date the application is signed.

Card Holder's Name (PLEASE PRINT): _____

Card Holder's Signature: _____

Date: _____

Rev. 10/2017

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Proposed Insured's Name: _____

Date of Birth:_____ **SSN:** _____

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 or service providers. We may disclose all or part of the information, records and data we receive under this authorization to the MIB (Medical Information Bureau). I understand this authorization is needed for the purpose of gathering information for making eligibility, underwriting and risk rating determinations.

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 including pharmaceutical/prescription records, drugs and diagnostic testing.

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 Health 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 Personal Representative**

_____ _____

Date **Print Name and relationship of Personal Representative**