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CHARTERED BY THE  
CONGRESS OF THE  
UNITED STATES



FRATERNAL LIFE  
INSURANCE  
FOUNDED IN 1896

March 2, 1907 A.D.

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**HUNGARIAN REFORMED FEDERATION OF AMERICA**  
A FRATERNAL BENEFIT SOCIETY  
WASHINGTON, D.C.  
*(HEREINAFTER REFERRED TO AS "THE FEDERATION")*  
**APPLICATION FOR ADULT INSURANCE**

**PART I.**

QUESTIONS BELOW APPLY TO THE PROPOSED INSURANCE OF THE APPLICANT.  
ALL STATEMENTS IN THIS APPLICATION ARE REPRESENTATIONS, NOT  
WARRANTIES.

1. **A.** Name of proposed insured.
 

	First	<input type="text"/>
	Middle	<input type="text"/>
	Last	<input type="text"/>
<i>(If married woman, maiden name also).</i>	Maiden	<input type="text"/>
- B.** Sex: Male  Female
- C.** Marital Status: Single  Married  Widowed  Divorced  Separated
- D.** Social Security Number:  -  -
2. **A.** Date of Birth: (MM/DD/YYYY)  /  /
- B.** Age: (Nearest Birthday)
- C.** Place of Birth:
 

City	<input type="text"/>
State	N/A - Other <input type="button" value="v"/>
- D.** Religion:
3. **A.** Address:
 

Street	<input type="text"/>
City	<input type="text"/>
State	N/A - Other <input type="button" value="v"/>
ZIP	<input type="text"/> - <input type="text"/>
Phone	<input type="text"/>
E-mail	<input type="text"/>
4. **A.** Plan of insurance applied for: Life Paid at Age 80
- B.** Amount: \$  2000
- C.** State requested riders: None
- D.** Amount: \$  2000
5. **A.** Method of payment: Monthly  Quarterly  Semi-annually   
Annually  SPWL

**6. Beneficiary(ies).**

Primary.	Full name	<input type="text"/>
	Relation	<input type="text"/>
Secondary.	Full name	<input type="text"/>
	Relation	<input type="text"/>

**7. A. Occupation and Duties:**

**B.** Do you fly or intend to fly as a pilot or crew member? Yes  No   
*(If yes, please fill out questionnaire)*

**8.** Is the Applicant a member of the Federation? Yes  No  Certificate No.

**B.** List all life insurances in force on life of Applicant:

Company	<input type="text"/>	Company	<input type="text"/>
Amount	<input type="text"/>	Amount	<input type="text"/>
Date issued	<input type="text"/>	Date issued	<input type="text"/>

**9.** Is the insurance applied for intended to replace in whole or in part, any existing policy? Yes  No   
 Company   
 Amount: \$

**10.** Have you ever made application for Life, Accident, or Health insurance upon which action was postponed, or certificate issued with increased premium or for an amount other than applied for, or upon which a Certificate was not issued, or later cancelled recalled or reinstated denied? Yes  No

**11.** Family record:

	LIVING		DEAD	
	Age	State of Health	Age	Year & Cause of Death
Spouse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sister	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**12.** Remarks:  
*(Please give details of all "Yes" answers. Dates-Durations-Results-Doctor's names and addresses.)*

**PART II. DECLARATION OF INSURABILITY**

To proposed Insured age 16 and over and to payor proposed for payor benefits. Answers must be made and signed in the presence of a representative of the Federation.  
*(If your answer is "yes" to any questions, specify details in "Remarks".)*

**13. Height & Weight**Height Weight **A.** Are you in good health?Yes  No **B.** Have any of your family members including your parents, brothers or sisters had mental trouble, epilepsy, tuberculosis, cancer, diabetes or heart disease, or committed suicide?Yes  No **14.** Have you ever been told that you had any of the following diseases or ailments or received treatment for:  
(If your answer is "yes" to any questions, specify details in "Remarks".)**A.** Dizziness, fainting, convulsions, St. Vitus' Dance, sinus, headache, insomnia, fractured skull, concussion of brain, epilepsy, paralysis or stroke; mental or nervous disorder?Yes  No **B.** Chronic cough, spitting of blood, bronchitis, pleurisy, throat trouble, asthma, emphysema, allergies, advised to change residence for health reasons, tuberculosis or other respiratory disorder?Yes  No **C.** Chest pain, shortness of breath, high or low blood pressure, abnormal pulse, rheumatic fever, heart murmur, varicose veins, or any disorder of the heart or blood vessels, anemia or other disorder of the blood?Yes  No **D.** Indigestion, diarrhea, ulcer, appendicitis, blood in stool, gall bladder or liver disease, colitis, rectal disease, hernia or any abdominal disorder?Yes  No **E.** Sugar, albumin, blood or pus in urine; diabetes (*used insulin*); venereal disease (*syphilis*); stone or any disorder of kidney, bladder, prostate or reproductive organs?Yes  No **F.** Thyroid, or other endocrine disorders?Yes  No **G.** Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?Yes  No **H.** Disorder of skin, lymph glands, cyst, tumor or cancer?Yes  No **I.** Excessive use of alcohol, tobacco or habit-forming narcotic drugs?Yes  No **15. A.** Did you consult any physician, surgeon, or practitioner during the past five years for examination, treatment or surgery?Yes  No *State name, address of physician, dates of disease and result of treatment in "Remarks".*

**B.** Have you ever been in a hospital, clinic, sanitarium or institution for observation or treatment?

Yes  No

*State name, address of place; specify disease and result of treatment in "Remarks".*

**C.** Did you have an X-ray, electrocardiogram, blood, urine or other special test during the past five years for any ailment or disease?

Yes  No

**D.** Were you rejected, deferred or discharged by the armed forces for physical or mental condition?

Yes  No

**E.** Do you ever make aerial flights other than as fare-paying passenger on scheduled airlines, or contemplate any?

Yes  No

**F.** Did you ever apply for or receive a pension or disability benefit?

Yes  No

**16.** If your answer is "yes" to any questions, specify details in "Remarks".

**A.** To the best of your knowledge, are you pregnant now?

Yes  No

**B.** Have you ever had a menstrual disorder or been told that you have any tumor or disease of the breast or other female organs?

Yes  No

**C.** Have you ever had a miscarriage, difficult labor, stillborn, or Caesarian operation?

Yes  No

**D.** Have you passed the change of life?

Yes  No

**E.** Have you had any bleeding or discharge since?

Yes  No

**F.** Do you have any children?

Yes  No

**(State number and specify any complications connected with pregnancies and birth in "Remarks".)**

### **PART III. DECLARATION**

**20.** The Applicant declares that to the best of his (her) knowledge and belief, the answers and statements made to the questions of Parts I and II are complete and true. The above answers were made to secure insurance applied for from the Federation. The Applicant agrees that if a medical application be required by the Medical Director of the Federation, the report of said examination will become a part of the Certificate issued by the Federation.

Signature	Proposed Insured's Signature	<input type="text"/>
	Date	<input type="text"/>
<input type="button" value="Submit"/>	<input type="button" value="Reset"/>	