THE SUPREME COUNCIL OF THE ROYAL ARCANUM

61 Batterymarch Street, Boston, MA 02110 1-888-272-2686 APPLICATION FOR GRADED DEATH BENEFIT

WHOLE LIFE

SINCE THIS POLICY IS ISSUED WITH MINIMAL OR NO MEDICAL UNDERWRITING, THE PREMIUM RATE CHARGED INCLUDES AN EXTRA MORTALITY RISK CHARGE. IF YOU ARE HEALTHY ENOUGH TO QUALILFY AS A "STANDARD" RISK, PREMIUMS WOULD LIKELY HAVE BEEN LOWER IF YOU HAD APPLIED FOR A FULLY UNDERWRITTEN POLICY.

Amount Collected Agent # 1111	<u>B</u>			
\$50.00				
Please Print all Answers. Do not use w	hite out. All cor	rections must be in	itialed by Applicant.	
Is Adult Applicant a Member? NO Counc			All	or
Applicant hereby applies for membership			10/09/	
repriedit nerecy applies for memorismi	,. 			
APPLICANT INFORMATION	687			
John R. Sample	000-00-	0000		
First Name, Initial, Last Name of Applicant	000 00		ecurity Number	
That I talle, Millian, East I talle of I approxim				
05 20 1964	N/A			
Month Day Year Male Femal	e la la	Maiden	Name	
Date of Birth Sex	0 01		(01.4) 000 0000	
New York, U.S. Place of Birth (State or Country) NY, U.S.	Occupation Occupation		(914) 000-0000 Residence Phone	
99 Franklin St.	Buffalo	NY	00000	
Residence Address (street or Route & Box #)	City	State/Providence	Zip Code	
	A STATE OF THE PARTY OF THE PAR		Andrew A. Administration	
Amount of Insurance \$25,000 Send Premium No	otice to: Insured	Owner <u></u> if Owner, give	address on line above (same)	
Automotic Dramium Loan cleated? Vos./ No.				
Automatic Premium Loan elected? Yes ✓ No _	- 40			
Premiums Annual Semi-Annual	Quarterly	Check-o-Matic ✓		
Is this insurance intended to replace any exiting		uities? Yes No	<u>~</u>	
(If "yes," give company name, address & poli	icy number)			
Owner Information (If Other Th	ıan Applicant	(same as prop	osed insured)	
First Name, Initial, Last Name	Relationship to A	Applicant	Social Security Number	
	11 180 001 Section = 2011 050 000. ★ 110 EVENTS 100	••		
			7: 0.1	
Residence Address (Street or Route & Box #)	City	State/Providence	Zip Code	
DDIMADY DENERICIADY CEA	CTION			
PRIMARY BENEFICIARY SE			1000/	
Marie M. Sample		000-00-0000	100%	
First Name, Initial, Last Name	Relationship to A	Applicant	Share %	
First Name, Initial, Last Name	Relationship to A	applicant	Share %	
Form No.: gblapp.ny	Page	1 of 2	For use in New York	
1 orin 140 golappiny	1 age	1012	I of abe in from I offe	

CONTINGENT BENEFICARY SECTION

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

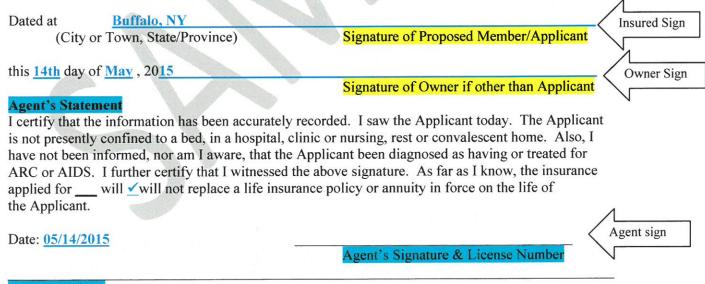
DECLARATION OF INSURABILITY—I hereby declare that I am not now confined to a bed, or in a hospital, clinic, rest or convalescent home. I have not been diagnosed as having or treated for ARC or AIDS.

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; 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.

EFFECTIVE DATE OF INSURANCE - The Effective Date of insurance is the date of the application if the premium is paid with the application. Otherwise, the Effective date of insurance is when the application is complete and the first premium is paid.

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

CHANGES AND CORRECTIONS—Any changes or corrections of the application which have been approved by the applicant in writing will be made in the "Home Office Endorsements" section of the policy form or by an Amendment to the application which will be attached to the policy. Acceptance of any policy issued shall be acceptance of any changes or corrections made by then Order and approved by the Applicant.



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 this 14th day of May,

2015, 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 on the following conditions:

CONDITIONS OF RECEIPT

This receipt is not valid unless the amount paid with the Application, if paid by check or draft, is Honored on first presentation for payment.

The payment of premiums is received subject to the following conditions:

If the Society at its Home Office is satisfied that, at the time of completing the application, the Proposed Insured was insurable under the Society's rules for insurance on the plan, in the amount and at the class of risk being applied for and the first premium has been paid; then, but only after these conditions are met, the Policy applied for will be effective from the date of the application.

If less than the full first annual premium has been paid, the Policy will remain in effect only for the fraction of one year that the payment made bears to the annual premium for such Policy.

This receipt is not transferable. This receipt is not valid unless it is signed by an agent of the Society.

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

Date: <u>05/14/2015</u>	Agent's Signature & License Number	Agent Sign
Agent's Address	Agent Print Name	-
Date: <u>05/14/2015</u>	Proposed Member	Owner Sign



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 s	urrendered, forfeited, assigned to the	insurer replaci	ng the life
insurance policy or annuity con	ntract, or otherwise terminated?	Yes	No <u>✓</u>
(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-fo	orfeiture benefit,
	end cash values or other cash value?		No 🗹
(3) Changed or modified so as to ex	ffect a reduction either in the amount	t of the existing	g life insurance or
annuity benefit or in the period	of time the existing life insurance or	annuity benef	it will continue in
force?		Yes	No 🗹
(4) Reissued with a reduction in an	nount such that any cash values are re	eleased, includi	ng all transactions
where dividend accumulations	or paid-up additions are released on	one or more of	the existing
policies?		Yes	No 🗹
loan value, including all transa	n or made subject to borrowing or wit ctions wherein any amount of dividen within on one or more existing policion	nd accumulatio	
	remium payments or reduction in the		
(o) continued with a stoppage of p	omani paymonis or roduction in the	Yes	No ✓
If you have answered ves to any of	the above questions, a replacement a		Contract of the contract of th
	as occurred or is likely to occur and		
	Statement: and the "Important notice		
of life insurance policies or annuity		Bar arm B b	accomment or commission
or me mourance penetral en			4
The state of the s			
The state of the s		•	APPLICANT
DATE: SIGNATU	RE OF APPLICANT:		
TO THE DECT OF MY WHOM FE	CE A DEDI A CEMENTE IC INVIOLE	ED IN THIS T	DANCA CETON
	OGE, A REPLACEMENT IS INVOLV	ED IN THIS I	RANSACTION:
YES NO <u>✓</u>		•	AGENT
DATE. CICNATU	DE OEACENT.		



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

	John R. Sample
Proposed Insured's Name:	•
05/20/1964	000-00-0000
Date of Birth	SSN:
medical related facility, health car- Information Bureau or other organ	ny licensed physician, medical practitioner, hospital, clinic or other medical or e provider or any mental health care provider, insurance company, the Medical nization, institution or person, that has any records or knowledge of me or any family to give such information to the Supreme Council of the Royal Arcanum or its
possession, under your control or authorization may include informa	I is: my full, complete and entire medical record, all information and data in your that you have access to. I understand that the medical information released by this tion concerning treatment of physical and mental illness, alcohol/drug abuse quired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) bry.
Term of this Release: I understa from the date of signing.	and this authorization will expire, without my express revocation, thirty (30) months
Revocation of Authorization: Leatent that action has been taken	understand that I may revoke this authorization in writing at any time except to the based on this authorization.
Portability and Accountability Act or regulations, create a right of privace I understand that authorization for authorization. I understand that all	and Data may not be Protected: I understand that the Heath Insurance of 1996 (HIPAA), HIPAA regulations as well as other Federal and State laws and by that is associated with the records, information and data covered by this release, the disclosure of this health information is voluntary and I can refuse to sign this my disclosure of information carries with it the potential for an unauthorized rey not be protected by federal confidentiality rule.
Photographic Copy: A photogra	phic copy of this authorization shall be as valid as the original.
Receipt: I/We acknowledge receipt	ot 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

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.

Form No.: app.addendum Page 1 of 2 For use in all states except Ohio



SAMPLE

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

Form No.: app.addendum

Page 2 of 2

For use in all states except Ohio





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
John Sample	000-00-0000
Applicant's Name (printed)	Social Security Number
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
This form mus	st be attached to the application.

FOUNDED BOSTON 1877

SUPREME COUNCIL OF THE

BENEFITS PAID 0VER \$ 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.

John Sample	DATE	05/15/2015		
(Please Print Clearly)				
NAME Federal Credit Union		CHECKING	√	SAVINGS
UTING NUMBER 000000000	ACCOUN	IT NUMBER	1231	123123
N/A home office use				
SIGNA	TURE			
		(Payor's si	gna	iture)
	(Please Print Clearly) NAME Federal Credit Union UTING NUMBER 000000000 N/A home office use	(Please Print Clearly) NAME Federal Credit Union UTING NUMBER 000000000 ACCOUN N/A home office use SIGNATURE	(Please Print Clearly) NAME Federal Credit Union CHECKING UTING NUMBER 000000000 ACCOUNT NUMBER N/A home office use SIGNATURE	(Please Print Clearly) NAME Federal Credit Union CHECKING ✓ JTING NUMBER 000000000 ACCOUNT NUMBER 123 N/A home office use

PLEASE ATTACH YOUR VOIDED CHECK HERE



CREDIT CARD AUTHORIZATION FORM

Please answer all questions completely.
John Sample (914) 000-0000
Cardholder's name:Tel:
Billing Address: 99 Summer St.
Street
Anywhere, NY 00000
City State Zip Code
✓ VISA
MASTERCARD
0 0 0 0 0 0 0 0 0 0 0 0 0
Card Number
Expiration Date:
Discos shows not so lit will be at
Please charge my credit card on a: Date of Debit:
\checkmark 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.
John Sample
Card Holder's Name (PLEASE PRINT):
Card Holder's Signature: Sign Here
Date:
For office use only
Policy #: Name of Insured:
Additional Policy: :
Amount to be charged: