Greek Catholic Union of the USA

5400 Tuscarawas Road, Beaver, PA 15009
1-800-722-4428

Irrevocable Burial Trust Agreement

GREEK CATHOLIC UNION OF THE USA
OPTION TO APPLY FOR A "BURIAL TRUST"

Available on new and existing Whole Life policies

Protection of assets at any age is important, but especially so when faced with the need for nursing home services, Medicaid and Supplemental Security Income. One option that may help to preserve eligibility for these services, while at the same time protecting assets from the reach of creditors, is to place your Greek Catholic Union of the USA life insurance policy in the Greek Catholic Union of the USA Irrevocable Burial Trust Agreement.

Upon naming the Irrevocable Burial Trust as the irrevocable beneficiary, the Trust becomes the Owner of the policy and as Trustee, is obligated to apply the policy proceeds towards burial, funeral, and end-or-life needs up to the face amount of the policy. The benefit of naming the Irrevocable Burial Trust as Owner is that it may help the insured qualify for Medicaid and Social Security Income eligibility.

A further benefit is that the policy proceeds, to the extent they are applied to end of life needs, would in most cases be protected from claims made by creditors, including the state and federal government. Any proceeds unnecessary for burial or funeral expense would be paid to the insured's estate and would then be available to creditor's claims.

Because the policy proceeds are to be applied to end-of-life needs, the benefits avoid the cost and delay probate, and because they constitute life insurance proceeds, they are tax-free upon death.

COMPLETING THE IRREVOCABLE TRUST AGREEMENT

- When completed for a NEW Life Insurance application:
  - On the Life Application:
    - Use Proposed Insured's **Full Legal Name**.
    - Indicate in the ownership section that the Proposed Insured is the **Owner**.
    - List the Primary Beneficiary as **"The GCU Irrevocable Life Insurance Burial Trust"**. (Eligibility for additional primary beneficiaries varies by State)

- When completed for an EXISTING Life Insurance application:
  - Only the actual Irrevocable Trust Agreement forms are required. A new Life Application is not necessary.

- In order to complete the requirements of the Burial Trust, The Grantor must be both the Insured and Owner of the policy.

- Only Greek Catholic Union of the USA life insurance policies are eligible. Minimum issue face amount is **$7,500**. In some cases, the minimum issue and the maximum amount permitted by State law will be the same.

- The total face amount of the policy or policies placed in the Trust may not exceed the following for residents of each state:
  - **Arizona:** $15,000
  - **California:** $15,000
  - **Florida:** $15,000
  - **Georgia:** $10,000
  - **Illinois:** $15,000
  - **Indiana:** $10,000
  - **Maryland:** $15,000
  - **Minnesota:** $15,000
  - **New Jersey:** $15,000
  - **North Carolina:** $10,000
  - **Ohio:** $15,000
  - **Pennsylvania:** $15,000
  - **South Carolina:** $15,000
  - **Texas:** $15,000
  - **Virginia:** $15,000
  - **Wisconsin:** $15,000

- This product is NOT available in Michigan, West Virginia, or Connecticut

- The Contingent Beneficiary of the policy or policies placed in the Trust must be the estate of the insured, unless otherwise prescribed by law.

The representations contained herein are not guarantees and do not constitute legal or tax advice, nor do they insure that this product is appropriate for the client's situation. Before purchasing any life insurance product, the client should seek the advice of an attorney and an accountant. Laws are subject to change and may result in the treatment of this product negative to the client's situation.

I hereby acknowledge that I have read, understand, and accept the terms, conditions and explanations as set forth above.

____ ________________________

Signature of Applicant Date

Greek Catholic Union of the USA

5400 Tuscarawas Road, Beaver, PA 15009
1-800-722-4428

Irrevocable Burial Trust Agreement

Grantor/Owner: ____ Date of Agreement: ________________

Beneficiary: Greek Catholic Union of the USA Irrevocable Burial Trust, as Trustee of the

____Trust.
(Name of Grantor/Owner)

Life Insurance Policy

Life Insurance Company: Greek Catholic Union of the USA

Insured: ____

Life Insurance Policy #: ____

Initial Amount of Insurance: ____

THIS IRREVOCABLE TRUST AGREEMENT is entered upon the following terms and conditions:

1. **TRUST ESTATE:** The Grantor hereby establishes this Trust and names the Greek Catholic Union of the USA Irrevocable Burial Trust as irrevocable and Trustee of the Trust. The Grantor has named the Trust beneficiary of certain life insurance policy/ies on the life of the Insured as shown above. The life insurance policy/ies and the benefits payable thereunder are hereafter referred to as the "Trust Estate". The Trust Estate shall be held and distributed in accordance with trust provisions and for the purposes state herein.

2. **TRUST AS BENEFICIARY:** The Trust shall be the irrevocable beneficiary of the life insurance proceeds. Neither the Trust nor the Trustee shall have the responsibility to pay the premiums for the life insurance policy/ies. The Grantor shall pay all premiums due for the life insurance policy/ies. Should the life insurance policy/ies lapse or otherwise terminate, this Trust shall also terminate concurrently.

3. **DISTRIBUTION UPON DEATH:** Upon the death of the Insured, the surviving spouse, estate of the Insured, or funeral home shall notify the Insurer indicated above and provide the necessary proof of loss to Trustee. The Trustee shall then claim the life insurance proceeds payable under the life insurance policy. The Trustee shall only distribute said life insurance proceeds to pay for the purchase or rental of personal property or professional services for the final disposition of the Insured's body ("funeral expenses"). Trustee, in its sole discretion, shall determine the amount of any such payments and the persons or organizations to receive such payments. However, in no event shall Trustee be required to pay any amount in excess of said life insurance proceeds. Any life insurance proceeds in excess of funeral expenses described herein shall be paid by the Trustee to the estate of the Insured.

4. **POWERS OF TRUSTEE:** The Trustee is hereby authorized to and shall perform all acts necessary in fulfilling the purpose and intent of this Agreement. The Trustee shall not be liable for any mistake or error of judgment in the administration of the Trust, including but not limited to distributions made pursuant to Paragraph 3. Any Successor Trustee shall have and may exercise all the rights, powers, duties and discretions conferred or imposed on the original Trustee. The Grantor expressly waives any requirement the (1) the Trustee be bonded; (2) the Trust or any separate trust created by this Agreement by submitted to the jurisdiction of any court; (3) the Trustee be appointed or confirmed by any court; or (4) the Trustee's accounts be heard and allowed by any court. The Trustee shall not be required to obtain a court order to exercise any power or discretion under this Trust. These provisions, however, shall not prevent any of the beneficiaries or the Trustee from requesting any of the procedures waived in this paragraph.

5. **SPENDTHRIFT PROVISIONS:** No title in the Trust Estate, nor in the income therefrom, shall vest in the heirs of the Grantor, and neither the principal nor the income of this Trust shall be liable to be reached in any manner by the creditors of the Grantor or by the creditors of the heirs of the Grantor except as stated herein. Further, the Grantor and the heirs of the Grantor shall not have any power to alienate, encumber, anticipate or dispose of any interest in the Trust Estate, nor the income therefrom, except for the purpose of arranging for payment of the purchase or rental of personal property or professional services for the final disposition of the insured's body.

6. **IRREVOCABILITY AND ASSIGNMENT OF RIGHTS UNDER POLICY:** This agreement and the trust herein created are irrevocable. The Grantor shall have no power to alter, amend, or modify this Agreement in any way. Grantor further irrevocably assigns to the Trustee all ownership rights under the policy including but not limited to the rights to surrender the policy for cash, obtain a loan against the policy, elect to exercise any of the dividend options in the policy, or reassign ownership of the policy or change the beneficiary of the policy.

7. **REPRESENTATIONS OF GRANTOR; INDEMNIFICATION:** Grantor acknowledges and agrees that Trustee, its employees, officers, and agents are not attorneys at law and have not provided the Grantor with any legal advice with regard to this agreement, including but not limited to its legal operation or effect, its coordination with the estate planning, if any, of the Grantor, and the availability of the insurance or its cash value as an asset for Medical Assistance eligibility. Grantor further acknowledges that this trust does not conflict with or duplicate any other trust or estate instrument or any other agreement relating to the payment of his or her funeral expenses. Grantor further acknowledges and agrees that he/she has had the opportunity to have this agreement reviewed by legal counsel of his or her choice. Grantor represents to the Trustee that he/she has the legal capacity and authority to enter into this agreement. Grantor hereby indemnifies and holds harmless the Trustee, its employees, officers, directors, and agents from, against and in respect of any and all liabilities resulting from, arising out of or incurred in connection with or arising out of this agreement.

IN WITNESS WHEREOF, the parties thereto have set their hand and seal the day and year written above.

WITNESS:____________________________________ GRANTOR:____________________________

(*to be signed by the* ***Insured***)

TRUSTEE: ____________________________________

(*to be signed by the* ***GCU Home Office***)

GREEK CATHOLIC UNION of the U.S.A.

A Fraternal Benefit Society

5400 Tuscarawas, Beaver, Pennsylvania 15009-9513

Telephone: 800-722-4428

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

(Please print; use dark ink)

APPLICATION PART 1

1. Is the Proposed Insured a member of the Union? ☐ Yes ☐ No If no, apply for membership.
   Lodge No.: ______________________ Located at: ______________________

2. **PROPOSED INSURED**: ______________________
   First Middle Last
   Address: ______________________
   P.O. Box/Street City, State or Country, Zip
   Date of Birth:__________ Place of Birth: __________ Marital Status: __________ Gender: __________
   Soc. Sec. #: ______________________ Primary Telephone #: ______________________
   Occupation: ______________________ E-mail: ______________________
   Driver's License #: ______________________ Annual Income: $ ______________________

3. **LIFE PLAN**: ______________________ Coverage Amount: ______________________
   Riders (show amount when applicable): ______________________
   If spousal or child coverage rider is applied for, please complete the following:
   Name: ______________________ Relationship to Proposed Insured: __________Date of Birth:__________
   Name: ______________________ Relationship to Proposed Insured: __________Date of Birth:__________
   Name: ______________________ Relationship to Proposed Insured: __________Date of Birth:__________
   Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual Payment with this application: $__________
   Automatic Premium Loan, if available? ☐ Yes ☐ No

4. **DIVIDEND OPTION** (if dividends are declared): ☐ Purchase paid-up insurance, if available ☐ Paid in cash
   ☐ Applied to next payment due ☐ Left on deposit, at interest, with the Union

5. **OWNER** (if other than Proposed Insured):
   ______________________ SSN:______________________
   Name Relationship

6. **BENEFICIARY**:
   Primary 1: ______________________ SSN: ______________________
   Relationship to Proposed Insured: ______________________ Share: ______________________ %
   Primary 2: ______________________ SSN: ______________________
   Relationship to Proposed Insured: ______________________ Share: ______________________ %
   Primary 3: ______________________ SSN: ______________________
   Relationship to Proposed Insured: ______________________ Share: ______________________ %

   Contingent 1: ______________________ Relationship to Proposed Insured: __________ Share: ______ %
   Contingent 2: ______________________ Relationship to Proposed Insured: __________ Share: ______ %
   Contingent 3: ______________________ Relationship to Proposed Insured: __________ Share: ______ %

7. **DISCLOSURE OF EXISTING LIFE INSURANCE**:
   Does the Proposed Insured have any pending life insurance applications? ☐ Yes ☐ No
   Does the Proposed Insured currently have any life insurance or annuity contracts in force? ☐ Yes ☐ No
   Is the insurance applied for intended to replace any insurance policy or annuity now in force? ☐ Yes ☐ No
   If yes, furnish insurance company's name and address and the policy number to be replaced, if applicable.
   ____
   ____

Proposed Insured's Name: ___________________________

Please provide details to "Yes" answers in Remarks section. **Yes** **No**

8. Has the Proposed Insured used any form of tobacco within the past 24 months? ☐ ☐
9. Has any person proposed for coverage within the past 5 years:
   a) been convicted of driving while impaired (alcohol, drugs, other), had drivers' license revoked or suspended, or, within the last 24 months, plead guilty to or been convicted of 3 or more moving violations? ☐ ☐
   b) had an application for insurance declined, rated, or postponed? ☐ ☐
   c) flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so? ☐ ☐
   d) engaged in parachuting, scuba diving, racing or other hazardous sports or intend to do so? ☐ ☐
   e) used or is now currently using marijuana, narcotics, intravenous drugs, cocaine, barbiturates, hallucinogens, or been treated for drug or alcohol abuse or been advised by a doctor to limit the use of alcohol or any medication, prescribed by a physician or not? ☐ ☐
   f) used any alcoholic beverage? ☐ ☐

      If yes, provide the following: Type: ________________ Frequency: ____________ Amount: _____________
   g) been on parole or probation or been convicted of a felony or misdemeanor? ☐ ☐
10. Within the next 2 years, does any person proposed for coverage plan to travel or reside outside the U.S. or Canada? ☐ ☐
11. Is the Proposed Insured a U.S. citizen? ☐ ☐
12. Has any person proposed for coverage ever had, or been diagnosed as having or received treatment or medical advice from a member of medical profession for:
    a) abnormal blood pressure, chest pain, coronary artery disease, abnormal ECG, elevated cholesterol, stroke, transient ischemic attack (TIA), peripheral vascular disease or any other disorder or disease of the heart, blood vessels or of the cerebrovascular system? ☐ ☐
    b) cancer, tumor, polyps, basal or squamous cell carcinoma, abnormal moles or lesions, dysplastic nevi, malignant melanoma or any other malignancy, or any growth or lump that has not been evaluated by a physician? ☐ ☐
    c) diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder? ☐ ☐
    d) any ear, nose, throat, lung disorder, or any respiratory disorder, including sleep apnea? ☐ ☐
    e) any disorder of the stomach, intestines, rectum, liver, pancreas, kidney or bladder? ☐ ☐
    f) lupus, connective tissue disease, or any injury to or disease of the bones, muscles, joints, eyes, or skin? ☐ ☐
    g) epilepsy, seizures, brain disorder, tremor, multiple sclerosis, paralysis, Parkinson's, Alzheimer's disease, motor neuron disease or any other disease or disorder of the nervous system? ☐ ☐
    h) anxiety, depression, or an emotional, behavioral, mental or nervous disorder? ☐ ☐
    i) any disease, disorder, or abnormal screening or diagnostic tests related to the breast or reproductive organs? ☐ ☐
13. Has any person proposed for coverage ever:
    a) been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ ☐
    b) had an immune deficiency disorder or disease of the lymphatic system or immune mechanism except those related to the Human Immunodeficiency Virus (AIDS virus)? ☐ ☐
14. Other than as stated above, within the past 5 years, has any person proposed for coverage:
    a) consulted, received treatment or advice from, or been prescribed medication by any other member of the medical profession? ☐ ☐
    b) had any abnormal diagnostic or screening tests or within the past 2 years been advised by a member of the medical profession to have any diagnostic test, hospitalization, surgical procedure or treatment that has not been done? ☐ ☐
15. Have any of the Proposed Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer, stroke or any other hereditary disease? ☐ ☐

    (If yes, indicate family member, age at onset of illness, and, if applicable, age at death in Remarks section.)

16. Please indicate the Proposed Insured's:
   a) Current Height ________ Current Weight _________ Change in past year of 25 pounds or more? ☐ ☐
      Cause of weight change ____________________
   b) Name and address of usual physician ____________________
      Date and reason of last visit ____________________
      Treatment given or medication prescribed ____________________
      If none, please write "none" here ____________________

17. **REMARKS** (explain yes answers to questions 8-16):

Question #	Person	Illness/Condition	Date & Duration	Treatment & Results	Doctors & Hospitals

AGREEMENT-AUTHORIZATION-ACKNOWLEDGEMENT – GREEK CATHOLIC UNION OF THE USA

This authorization complies with the HIPAA Privacy Rule.

I understand I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of Greek Catholic Union of the USA.

I, the Primary Proposed Insured (and any Spouse or Owner signing below), by my signature set forth hereafter:

AGREE to the following:

a) All Statements and answers in this application are complete and true to the best of my knowledge and belief.
b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is delivered while the health of any proposed insured continues, without material change, to be as represented in this application.
c) No agent has authority to waive any answer or otherwise modify this application or to bind Greek Catholic Union of the USA, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this application.
d) $__________ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted.

AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy benefits manager, insurance support organization, pharmacy/government agency, insurance or reinsuring company, MIB, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company, or its reinsurers, to release any information including my personal health information obtained to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for the maximum length of time permitted by applicable law in the state where the policy/certificate is delivered or issued for delivery. I know that I or my representative may request a copy of this authorization. It is understood that Greek Catholic Union of the USA underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company, or its reinsurer, (or the Company, or its reinsurers, becomes obligated to report such codes to MIB) while this authorization is in force. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage.

ACKNOWLEDGE receipt of the following notices:

a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and
b) MIB Pre-Notice.

FRAUD WARNING NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GREEK CATHOLIC UNION OF THE U.S.A. IS LICENSED TO DO BUSINESS AS A FRATERNAL BENEFIT SOCIETY. AS SUCH, IT IS NOT INCLUDED IN ANY STATE'S LIFE AND HEALTH GUARANTY ASSOCIATION (OTHERWISE KNOWN AS THE GUARANTY ASSOCIATION). THIS MEANS THAT FRATERNAL BENEFIT SOCIETIES CANNOT BE ASSESSED FOR THE INSOLVENCY OF OTHER LIFE INSURERS OR OTHER FRATERNAL BENEFIT SOCIETIES. BY LAW, A FRATERNAL BENEFIT SOCIETY IS RESPONSIBLE FOR ITS OWN SOLVENCY. IF THERE IS AN IMPAIRMENT OF RESERVES, A CERTIFICATE HOLDER MAY BE ASSESSED A PROPORTIONATE SHARE OF THE IMPAIRMENT. THIS PROCESS IS DESCRIBED IN THE CERTIFICATE ISSUED BY THE SOCIETY.

____
Date

Printed name of Proposed Insured	Signature of Proposed Insured (or parent if Proposed Insured is under age 18)
Printed name of Spouse (if proposed for rider coverage)	Signature of Spouse (if proposed for rider coverage)
Printed name of additional Proposed Insured	Parent or Guardian (Juvenile Proposed Insured); or Member Applicant
Owner (if other than Proposed Insured)	

Proposed Insured's Name: ___________________________

AGENT'S REPORT

		Yes	No
1.	**Agent Checklist (provide details in Additional Remarks section below):**		
a)	Did you give the applicant a copy of the Privacy Notice and other disclosure information?	☐	☐
b)	Are you related to the Proposed Insured?	☐	☐
c)	Was this application taken in person?	☐	☐
d)	Do you know anything not disclosed which might affect the underwriting of this risk?	☐	☐
e)	Is there another application currently pending or being submitted to any other life insurance company?	☐	☐
f)	Has the Proposed Insured applied elsewhere for any insurance coverage within the past 6 months?	☐	☐
g)	Is replacement of existing insurance involved in this application? (If yes, submit appropriate replacement forms.)	☐	☐

2. **If the Proposed Insured is age 0-16, please answer the questions below:**

a)	Number of siblings ______ Do they all have the same amount of insurance as the Proposed Insured?	☐	☐
b)	If less than 1 year of age, what was the birth weight? ___________ lb. ____________ oz.		
c)	Did you see the child?	☐	☐
d)	Amount of life insurance in force and/or requested on: Father $ ____ Mother $ ____		

3. **Information for Business Insurance (e.g., Buy/Sell, Split Dollar, Key Person, etc.)**

a)	Is this insurance part of a split dollar agreement?	☐	☐
b)	This business operates as a: ☐ Regular Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship		
c)	What is the value of the business? $ ________________________		
d)	What percentage does the Proposed Insured own or control? ____________________ %		
e)	Are other key individuals applying? If yes, indicate name of each person. If no, for what reason? (use space below for details)	☐	☐

____

____

____

____

I certify I have accurately recorded all information given by the Proposed Insured and my statements on this Agent's Report are correct to the best of my knowledge. I claim full credit for this application unless other instructions are given below.

Date ______________________________ Agency ___________________________________ Code ___________

Agent's Signature ____ Code ___________

Agent's Signature ____ Code ___________

CONDITIONAL RECEIPT

GREEK CATHOLIC UNION OF THE USA

TERMS AND CONDITIONS - Coverage issued bearing the date of this receipt will become effective on the date of the application or last medical examination, whichever is later. Coverage will be provided when the following conditions are met:

1. The application and required information is received at our Home Office.
2. All persons proposed for coverage are insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
3. The full first premium is paid in cash on the date of application. The maximum amount of life insurance, including accidental death, which will become effective under this receipt cannot exceed $100,000. This includes any previously pending insurance.

There will be no conditional insurance coverage and the Company's liability will be limited to returning any premium submitted to the Company with this Receipt if any of the following occurs: (A) one or more of the receipt's conditions have not been met exactly; (b) any proposed insured dies by suicide

If the Policy is not issued exactly as applied for, it will become effective when it is delivered to and accepted by the applicant. Upon delivery and acceptance, the first premium must be paid. If the application is declined or not approved within sixty days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

GREEK CATHOLIC UNION OF THE USA

LIFE PLAN________________________________ **Amount $**____________________

ALL PREMIUM PAYMENTS MUST BE PAYABLE TO THE COMPANY.
DO NOT MAKE PAYMENTS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

By______________________________________ ____________ 20______
Agent Date

NOTICE OF INFORMATION PRACTICES

(including MIB Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

This Notice must be given to Proposed Insured

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING MIB, Inc, (" MIB")

Information regarding your insurability will be treated as confidential. GREEK CATHOLIC UNION OF THE USA, or its Reinsurer(s) may, however, make a brief report thereon to the MIB, a non-for profit membership organization of life insurance companies which 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 it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of and information it may have in your file by calling (866) 692-6901 or you can go to their website www.mib.com. If you question the accuracy of information in 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 MIB is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184.

GREEK CATHOLIC UNION OF THE USA, or its Reinsurer(s), may also release information in its files 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.

GCU
5400 Tuscarawas Rd, Beaver PA, 15009
P 1.800.722.4428 F 724-495-3421 E info@GCUusa.com

Authorization
For Blood Testing and Disclosure of Results

I do hereby authorize blood to be drawn from me for laboratory tests. I understand that:

1. The tests performed will be those required by the Insurer to determine my eligibility for the insurance I have applied for;

2. I have the right to refuse to have blood drawn and that, in such event, the Insurer will decline to accept my application; and

3. The tests preformed shall include, but are not limited to, tests for:

    a. Cholesterol and related blood lipids; glucose; liver or kidney disorder; or the presence of medication, drugs, nicotine or metabolites; and
    b. Immune disorders; or T-Helper to T-Suppressor ratio with total T-cell count.

I further authorize:

1. The laboratory to disclose the test results to the Insurer;
2. The Insurer to disclosed the test results, including any abnormal results, to its reinsurer, provided such reinsurer is involved in the determination of my eligibility for insurance; and
3. The Insurer to make a brief, coded report to the Medical Information Bureau (MIB) in the manner described in the MIB Notice I received as a part of my application process.

I understand that the test results will be confidential. No one will have access the test results except: as I have authorized; as I may later authorize; or, as may be required by law.

Name of Proposed Insured (Please Print): ______________________________

Address: ______________________________

____

Signature of Proposed Insured: ______________________________

Witness: ______________________________ ______________________________
(Signature) (Printed Name)

Date: ______________________________

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ ________

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

6 City, state, and ZIP code

Requester's name and address (optional)
GCU
5400 Tuscarawas Road
Beaver, PA 15009

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.