Czechoslovak Society of America

SIGNATURES / MIB AUTHORIZATION

I hereby declare that the statements and answers made by me on this application are complete and true and I agree that the completed application the certificate issued to me upon this application and the Constitution and Bylaws of the Czechoslovak Society of America, the medical examinations or the questions and my answers thereto concerning my insurability and all amendments of such documents, shall together constitute the entire contract of insurance between me and the Czechoslovak Society of America. I further agree that the same shall in no way be affected or modified by any statements or information given by or to any person soliciting or taking this application by or to any other person or by any information possessed by such person. I further agree, for myself and my beneficiary(ies), to abide by said Bylaws.

I hereby apply for membership in the Czechoslovak Society of America. If accepted, I agree to abide by the Articles of Incorporation and Bylaws of the Czechoslovak Society of America and the rules and regulations of said Lodge, all as the same now exist or are hereafter amended. I further agree to pay the required membership dues.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical or medically related facility or other health care provider, insurance or reinsuring company, consumer reporting agency, the MIB, Inc., or other organization, institution or person, having any records or knowledge of my health, to give to the Czechoslovak Society of America or its reinsurers any such information it may require to determine eligibility for insurance. I hereby authorize the Czechoslovak Society of America to use one of its approved vendors to check my usage of prescription medication. I authorize the Czechoslovak Society of America insurance organization or its reinsurers, to make a brief report of my personal health information to MIB. This authorization will be valid for 30 months from the date the authorization is signed and may be revoked at any time. A photographic copy of this authorization shall be as valid as the original. I understand that I (or my authorized representative) am entitled to a copy of this authorization.

I also acknowledge receipt of the NOTICE OF INFORMATION PRACTICES.

Date_____ Signature of Proposed Insured_____

Signature of Owner (if other than Proposed Insured)_____

MIB PRE-NOTICE

While the information regarding your insurability is treated as confidential, the Czechoslovak Society of America or its reinsurers may make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance or submit a claim for benefits to another member company, MIB upon request from that member company, will supply the information in its file. Upon written request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB's Information Office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734, telephone 866-692-6901. We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.