

APPLICATION FOR MEMBERSHIP

IN THE

ALLIANCE AID ASSOCIATION,

HURON, SOUTH DAKOTA.

All Applications Must be Written in Ink.

<p style="text-align: center;">NAME OF APPLICANT.</p> <p style="font-size: small;">Write the name plainly, correctly and in full.</p>	<p style="text-align: center;">RESIDENCE.</p> <p>Postoffice,</p> <p>County, State,</p>	<p style="text-align: center;">BUSINESS ADDRESS.</p>
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Amount of Policy, \$ Membership fee, \$ One Death Loss Assessment, \$
 Registry fee, \$1.00. Semi-Annual dues, 50 cents per each \$1,000 represented by Application.

1. PLACE AND DATE OF BIRTH OF APPLICANT:—Place County State Day Month
2. Year Age Years. Married or single?
3. For whose benefit is this Certificate to be issued?
4. Relationship to you?
5. OCCUPATION?
6. Are your habits at the present time, and have they always been, sober and temperate?
7. Are you now, and are you usually in good health?
8. Have you any other insurance on your life? If so, where, when taken, and for what amounts?
9. Do you understand and agree that the excessive use of alcoholic drinks, opiums or other narcotics, will forfeit your membership?

IT IS HEREBY WARRANTED by the Applicant that the answers and statements in this application, including the statements made to the Medical Examiner, were written with his full knowledge and consent, and are full, complete and true; and it is agreed that this warrant shall form the basis and shall be a part of the contract between the undersigned and the aforesaid ALLIANCE AID ASSOCIATION, and are offered to said Association, as a consideration of the contract applied for and subject to all its limitations and requirements, all of which are hereby made a part of the certificate to be issued on this Application. And the applicant further agrees, that if any of the statements, representations or answers made herein or in Medical Examiner's report of this application, are not true, or if he shall purposely withhold any circumstances in relation to past or present state of his health, habits or condition of life, which may render the risk upon his life more than usually hazardous, or if he or his representatives shall omit or neglect to make any payments as required by the conditions of such Certificate, then the Certificate to be issued hereon shall be null and void. It is understood that under no circumstances shall the Certificate hereby applied for be in force until this Application has been approved by the Medical Director at the Home Office. And it is further agreed, that the Association shall not be liable under said Contract if death shall be caused by the hands of justice, or in consequence of the violation of any statutory law.

I, do hereby make application to the said ALLIANCE AID ASSOCIATION, for a Certificate of Membership limited to

DOLLARS

And I further agree to pay all legal assessments made in conformity to the By-Laws and rules of said Association.

Dated at this day of 19.....

This Risk is approved and recommended by me, and I am witness to the signatures:

Agent. (Signature of the Applicant.)

MEDICAL EXAMINER'S REPORT.

Part 2. The MEDICAL EXAMINER is requested to be careful and minute in his examination, and after filling the blanks and answering the questions, to add under the head of Remarks any additional facts he may think necessary to a proper understanding of the case.

EXAMINATIONS MUST BE WRITTEN IN INK.

Name of Applicant examined Residence

1.	Age (if living)	Condition of Health.			Age at Death.	Cause of Death.		
FATHER								
MOTHER								
BROTHERS	How many has the person had?	How many Living?	Their Ages?	State of Health	How many are Dead?	At what age did they die?	Of what diseases did they die?	
SISTERS								

2. Have you ever been rejected by any Insurance Company?
3. Has any physician given an unfavorable opinion upon your life, with reference to Life Insurance, or otherwise? If so, state particulars

[OVER]

MEDICAL EXAMINER'S REPORT--CONTINUED.

4. Have any material facts regarding your past health or present condition been omitted? State facts fully.....
5. Name and residence of applicant's usual Medical Attendant?.....
6. Have you been successfully vaccinated?.....

Have you had, since childhood, any of the following complaints? Answer (Yes or No) opposite each.

Apoplexy.....	Disease of Kidneys.....	Insanity.....	Rupture.....	Give full particulars of any illness you may have had since Childhood. When were you last confined to the house by illness?.....
Asthma.....	Disease of Liver.....	Jaundice.....	Scrofula.....	
Bilious Colic.....	Disease of Lungs.....	Palpitation.....	Small Pox.....	
Bronchitis.....	Dis. of Urinary Organs.....	Paralysis.....	Skin Disease.....	
Cancer.....	Fistula.....	Piles.....	Spinal Disease.....	
Dropsy.....	Fits or Convulsions.....	Pleurisy.....	Spitting or raising blood.....	
Disease of Brain.....	General Debility.....	Pneumonia.....	Syphilis.....	
Disease of Heart.....	Gout.....	Rheumatism.....	Yellow Fever.....	

7. Are you personally acquainted with the applicant?.....
8. If so, how long?.....
9. Complexion..... Nativity.....
10. General appearance.....
- Weight..... Height..... Girth of waist.....
11. Forced expiration..... Forced Inspiration..... Figure.....
12. Is the Respiratory Murmur clear and distinct over every part of both lungs?.....
- A. Is the respiration full, easy and regular?.....
- B. Is there any indication of disease in the lungs?.....
- C. Number of respirations per minute?.....
13. Is the action of the heart uniform, free and steady?.....
- A. Are its sounds and rythm regular and normal?.....
- B. Is there any indication of disease of the heart or blood vessels?.....
14. State the rate and character of the pulse?.....
15. Is there any indication of disease of the urinary organs?.....
- (The urine must be examined where there is the slightest suspicion of any disorder of the urinary organs.)
- Specific Gravity..... Reaction.....
- Albumen..... Sugar.....
16. Does the applicant use ardent spirits, wines or malt liquors?.....
17. Does the applicant use opium or other narcotics?..... Has he ever used them?.....
18. Have you any reason to suppose that the applicant has ever led, or leads now, other than a sober and temperate life?.....
19. Has party a rupture?.....
20. If so, of what kind, single or double, is it reducible, and is a truss worn?.....
21. Are there any cutaneous eruptions on any part of the body, and if so, of what nature?.....
22. Are the functions of the stomach and abdominal organs perfectly healthy?.....
23. Has party any tendency, hereditary or acquired, to any local or constitutional disease?.....
23. A. Has party ever had severe illness or injury, or undergone any surgical operation?..... B. If so, give full particulars thereof.....
- C. If so, has it had any effect on the constitution?.....
- D. Is there any indication that the party is not now entirely well?.....
- E. Is the party deaf, dumb, blind, lame or maimed in any way?.....
24. Do you discover or suspect anything unfavorable to the risk not already fully stated above?.....
25. Has party any scar, defect, or special marks of identification? If so, what?.....
26. (If the applicant be a female, the following questions must be asked:)
- A. Have you any disease of the womb, or its appendages?.....
- B. Are you regular in menstruation?.....
- C. How many children have you had?..... D. Was the labor natural?..... E. Have you any disease of the breast?.....
- F. Have you ever miscarried?..... G. If so, how often?.....
27. After reviewing the applicant's state of health, would you consider it a first-class risk? A good risk or only a fair risk?.....
28. Do you recommend that the policy be issued. (Yes or no.).....
29. I hereby certify, that I have this day made a personal examination in private of the above named applicant, that the foregoing answers are in my own handwriting. I further state that I have been a practicing physician for..... years, that I am a graduate of.....
- I hereby declare that I have written and attentively considered the statements made to me as above by Mr.....
- I have carefully examined him in private at..... day of..... 189.....
- and I have witnessed the said person's signature as hereon.
- M. D., MEDICAL EXAMINER.
- APPLICANT'S DECLARATION.**
- I do hereby warrant, that my answers, as written, to the above questions, in the Medical Examiner's report, are full, complete, correct and true, and the same shall be made a part of the Contract of my Certificate of Membership in the ALLIANCE AID ASSOCIATION, and that I am the person who signed the application on the opposite side was expressed as above.
- Applicant Sign Here**.....

Spaces below to be filled out at the Home Office.

APPLICATION.

Alliance - Aid - Association.

Class..... Age.....

Membership..... \$.....

Assessment..... \$.....

No. of Policy..... \$.....

Amount.....

Name.....

P. O..... State.....

County.....

Date Approved..... 189.....

M. D.,
Medical Director.

Secretary.

How to Fill Out this Application.

Write your first or given names plainly and in full. Write out the application in ink. If possible answer every question. Always write given name of beneficiaries. If made payable to your wife, record her given name—thus, Mrs. Mary L. Smith, not Mrs. George H. Smith.

MEMBERSHIP RATES.

Div. A.....	\$5 00
Div. B.....	5 00
Div. A and B at same time.....	6 00
Registry fee.....	1 00

RATE OF ASSESSMENT.

ON EACH \$1,000.

Each Division limited to \$1,000.

Age from 18 to 25.....	\$1 00
" " 25 to 30.....	1 10
" " 30 to 35.....	1 25
" " 35 to 40.....	1 50
" " 40 to 45.....	1 75
" " 45 to 50.....	2 00
" " 50 to 55.....	2 00

Medical Examination fee additional to be paid by applicant.

Revised Print.