NATIONAL BENEFIT LIFE INSURANCE COMPANY
ONE COURT SQUARE, LONG ISLAND CITY, NY 11120-0001 • 800-222-2062

TO FACILITATE PROCESSING, PLEASE PROVIDE TELEPHONE NUMBERS AND PLACE OF BIRTH:

WORK: ( ) _____

HOME: ( ) _____

CELL: ( ) _____

PLACE OF BIRTH: _____

LIFE INSURANCE REINSTATEMENT APPLICATION

Name: _____ **Policy/Certificate No.**_____

With respect to each of the persons insured under this policy/certificate:

1. To the best of your knowledge and belief are you now disabled or suffering from any illness, injury or disease? YES ( ) NO ( )
2. Have you had any illness or personal injury of any kind or have you consulted, been operated on or treated by any physician or other practitioner since the Effective Date of your policy/certificate? YES ( ) NO ( )
3. Has any application for life or accident or health insurance been declined, modified or issued other than as applied for? YES ( ) NO ( )

GIVE DETAIL TO ALL "YES" ANSWERS BELOW:
(If more space is needed, use back of this form)

Name of Person	Illness, Disorder or Operation	# of Attacks	Dates From To	Any Remaining Effects	Names & Addresses of Physicians & Hospitals

The undersigned hereby certifies that the statements and answers contained in this application are complete and true to the best of his/her knowledge. I (we) further agree that all statements and answers in this application shall he taken as the basis of reinstatement.

It is further agreed that the reinstatement of the policy shall not become effective until:

A. This application is approved by National Benefit Life Insurance Co.;
B. Any outstanding indebtedness due the Company may either be repaid or reinstated.

If this policy is reinstated, the Company will not contest it with respect to statements made in the application for reinstatement materially relating to insurability after it has been in force for two years from the date of reinstatement and during the lifetime of the insured.

Signed at _____ this _____ day of _____ 20 _____

_____
Insured

_____
Owner (if other than insured)

_____
Spouse's Signature (if insured Under this Policy / Certificate)

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DISCLOSURE FOR MOTOR VEHICLE REPORTS, INVESTIGATIVE CONSUMER REPORTS AND MIB, INC.

As part of the Company's regular underwriting procedure, the Company may obtain a Motor Vehicle Report (MVR) showing detailed driving history and an Investigative Consumer Report (ICR), which will contain personal information concerning your character, habits, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If an ICR is obtained, personal interviews with your neighbors, friends, associates and acquaintances may be conducted. In the event that an ICR is obtained, you understand that you may request to be interviewed in connection with the ICR and that a right of access and correction exists with respect to the ICR and all personal information collected. Upon written request to the Company at One Court Square, Long Island City, NY 11120-0001, further detailed information on the nature and scope of both the MVR and ICR will be provided.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief Report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the 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's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file 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 MIB may be obtained on its website at www.mib.com.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION
For Use and Disclosure of Protected Health Information

By your signature below:

(1) You authorize National Benefit Life Insurance Company, its affiliates (collectively the "Company"), reinsurers, and authorized representatives, including agents, insurance support organizations, MIB, Inc., and service providers to receive your health information in any format (including but not limited to paper);
(2) You acknowledge that health information may include information about prescription histories, the diagnosis, treatment and prognosis of any physical or mental condition and the use of drugs or alcohol, but not psychotherapy notes;
(3) You authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, Veteran's Administration, government facility, pharmacy, pharmacy benefit manager, insurance company, clearinghouse, or other entity or person ("Providers") to disclose your health information;
(4) You acknowledge that this Authorization may be relied upon to determine your eligibility for insurance, to obtain reinsurance, to administer any claim for insurance benefits or for any other business purpose not otherwise prohibited, including but not limited to any activities related to coverage or benefits or to support the business operations of the Company;
(5) You acknowledge that this Authorization expires two (2) years from the date it is signed;
(6) You acknowledge that you may revoke this Authorization at any time by sending written notice to the Company's address, however, any revocation will not apply retroactively or prevent the Company from contesting a claim for insurance benefits or the policy itself;
(7) You acknowledge that if you refuse to sign this Authorization, a Provider may not refuse to provide treatment or payment for health care services, however, the Company may not be able to process this application or, if coverage is issued, make any benefit payments;
(8) You acknowledge that information disclosed pursuant to this Authorization may be redisclosed and no longer covered by certain federal rules governing privacy of health information; and
(9) You acknowledge that a photographic copy of this Authorization, including a photographic or electronic copy of your signature, is valid as the original and you may receive a copy of this Authorization after it is signed.

Date: Date:

_____ _____

Signature of Insured Signature of Additional Insured (if any)