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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Authorization and Acknowledgement Statement

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to the National Benefit Life Insurance Co. any such information. This authorization is valid only for 2 ½ years from the date signed. I also authorized National Benefit Life Insurance Co. to obtain a consumer investigative report, if necessary to underwrite this application.
I also acknowledge receipt of the NOTICE TO APPLICANT Parts One and Two. A photographic copy of this authorization and acknowledgement shall be as valid as the original.

Date: _____

_____ _____
Signature of Witness **Signature of Insured**

NOTICE TO APPLICANT – PART ONE

Federal law requires that notice of investigation be given to person applying for insurance or reinstatement.
In making this application for reinstatement, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to inspect and receive a copy of any report which is actually prepared.

NOTICE TO APPLICANT – PART TWO

Information regarding your insurability will be treated as confidential. National Benefit Life Insurance Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau upon request, will supply such company with the information in its file.
Upon receipt of a request from you, the bureau will arrange disclosure of any information it may have in your file (Medical information will be disclosed only to our attending physician. If you question the accuracy of information in the bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts, 02112, telephone number (617) 426-3660.
Company may also release information in its file to other life insurance companies to who you may apply for life insurance, or to whom a claim for benefits may be submitted.