NATIONAL BENEFIT LIFE INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3433• 800-222-2062

APPLICATION FOR REINSTATEMENT

Name of Insured _____ **Policy Number**_____

_____

Address

_____ _____

Address **Phone Number**

In consideration of the premium paid and the answers to the questions below, I hereby request reinstatement of the above policy. I declare that the answers to the following questions are true and complete to the best of my knowledge and belief and that the answers are deemed to be representations and not warranties.

(If additional space is required, attach a separate sheet).

1. What is your present occupation? (Give exact duties)

   _____

2. To the best of your knowledge and belief, do you or any other person insured under the policy have any adverse health conditions, impairments or disabilities? Yes ☐ No ☐ If yes, give complete details.

   _____

SINCE THE DATE OF ISSUE OF THIS POLICY:

3. Have you or any other person insured under the policy had any illness, injury, consulted or been treated by any physician? Yes ☐ No ☐ If yes, give details including date, duration and complete name and address of attending physician.

   _____

4. Have you or any other person insured under the policy made application for life or health insurance or for reinstatement that was postponed, declined or modified as to kind, amount or rates? Yes ☐ No ☐ If yes, give complete details.

   _____

5. Have you or any other person insured under the policy been an airplane pilot or received instructions in flying, or contemplate doing so? Yes ☐ No ☐ If yes, give details and enclose aviation form.

   _____

6. Have you or any other person insured under the policy been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or immune deficiency related disorders? Yes ☐ No ☐

7. In the past year have you or any other person insured under the policy smoked cigarettes? Yes ☐ No ☐
   If yes, give complete details including name of the person.

   _____

8. In the past 3 years have you or any other person insured under the policy used tobacco in any form? Yes ☐ No ☐
   If yes, give complete details including name of person.

   _____

I hereby certify that the foregoing statements and answers are correct and true to the best of my knowledge and belief and have been made by me to induce the Company to reinstate said policy. I agree (1) that the policy shall not be reinstated until this application has been approved by the Company: except, that is money is paid with this application, coverage will take effect only in accordance with the terms of the "conditional premium receipt"; (2) that if the policy is reinstated, no statement made herein shall be used by the Company to contest liability after the reinstated policy has been in force during the lifetime of the Insured for a period of two years from the date of such reinstatement; and (3) to accept return of an y amount paid herewith should the Company decline to approve this application.

Dated at _____ this _____ day of _____, 20 _____

X_____ X_____
Signature of Witness Signature of Insured

X_____ X_____
Signature of Spouse if to be Insured Signature of Owner, if other than Insured

CONDITIONAL PREMIUM RECEIPT

CONDITIONAL PREMIUM RECEIPT – I/We understand and agree that no insurance will be in effect before reinstatement of the Policy is approved by the Company and I/We receive written notice of such approval unless all Conditions set forth below are met. If all Conditions are met and my/our death occurs before reinstatement is approved by the Company, then there shall be coverage but only in accordance with the provisions of this receipt and any Policy provisions not in conflict with it. If the Policy cannot be reinstated as originally issued, then all premiums paid will be returned and any coverage under this Receipt will terminate.

CONDITIONS FOR COVERAGE – 1) All information given by me/us in the application must be true and complete to the best of my/our knowledge and belief; 2) The Company must find the person(s) to be insured acceptable on the same risk basis as originally issued according to its underwriting rules: 3) At least one month's premium for the Policy applied for must be paid with the application, but not to exceed the amount of premium required for $500, 000 of coverage.

EFFECTIVE DATE OF COVERAGE – Any coverage under this Receipt will become effective on the latest of the following: 1) Date of this Application; or 2) The first medical examination initially required or the second medical examination if required by the Company's published underwriting rules due to the Proposed Insured's age or amount of Insurance applied for, in connection with this application.

LIMITS OF COVERAGE – The amount applied for and for which premium had been paid, but not to exceed $500,000 for all coverage applied for under this application.

I hereby acknowledge that I have read and I understand the conditional coverage under this receipt and understand these conditions cannot be changed by any agent of the Company, as evidenced by my/our signature below.

Dated at _____ this _____ day of _____, 20 _____
City, State and Zip Code

_____ **X**_____
Name of Minor Child — Signature of Proposed Insured or Parent of Minor Child

X_____ **X**_____
Signature of Owner if other than Proposed Insured — Signature of Spouse if to be Insured

AGENT CERTIFICATION

I certify that: (1) I personally have asked and recorded completely and accurately the answers to all questions on this application; and (2) I saw the applicant sign the application and that to the best of my knowledge and belief all answers on all completed parts are true: and (3) I know of nothing affecting the risk that has not been recorded herein; and (4) I have read and explained to the applicant (s) the provisions of any Conditional Premium Receipt I have given for any premium submitted with this application. I have not made any proposal to or agreement with anyone whereby the applicant or any other person has received directly or indirectly, in settlement f the premium on the proposed insurance, any concession or rebate from the regular premium, and I assume full responsibility for the delivery to the Company of payment of any premium submitted by the applicant in connection with this application.

X_____ _____ _____
Signature of Licensed Agent — Date — Phone Number

_____ _____ _____
Print Name of Licensed Agent — Agent Code Number — Distribution Number

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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 111200001, 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 866692-6901 (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)