LIFE: ☐ Traditional ☐ Variable **ANNUITY:** ☐ Fixed ☐ Variable
(Term, UL, WL)

RBC Insurance

REINSTATEMENT APPLICATION

Business Men's Assurance Company of America PO Box 19087 Greenville, SC 29602-9087

1.800.234.5514 ■ Traditional/Fixed Annuities
1.800.423.9398 ■ Variable Life/Annuities

Name of Proposed Primary Insured: *(PLEASE PRINT)*	Proposed Insured's Birthdate:	Policy Number:

Please answer each question below for all persons proposed for reinstatement:

Since the date of the original application for this policy, has any person :	Yes	No
1. Had symptoms of or consulted a physician for, been diagnosed as having, been treated for, or been advised to have diagnostic tests for, any illness or injury or other physical disability or impairment, including but not limited to: (a) heart trouble, high blood pressure or stroke? (b) cancer, tumors, diabetes or blood disease ***(excluding tests for HIV, AIDS, or ARC)***? (c) disorder of the lung, liver, kidney, digestive or urinary tract, or reproductive organs? (d) mental or nervous disorders, or epilepsy?	☐	☐
2. Acquired Immune Deficiency Syndrome (AIDS)? Answer "no" if you are HIV positive and have not developed symptoms of the disease AIDS.	☐	☐
3. Had unexplained weight gain or loss in past year? (If so, which and how much? Ignore child's normal growth if it falls within the normal range on a child's growth chart)	☐	☐
4. Used drugs (except as prescribed by a physician) or been counseled, treated or arrested for the use of drugs or alcohol, including DWI or DUI?	☐	☐
5. Missed any days, or partial days of work or been unable to perform any normal activities or job duties in the past six months because of illness, injury, or other physical or mental impairment?	☐	☐
6. Flown, or intend to fly, as a pilot or crew member; race any form of vehicle; skin or scuba dive; hang glide or sky dive, or engage in rodeo competition?	☐	☐
7. Received a prescription for medication?	☐	☐

8. GIVE COMPLETE DETAILS BELOW FOR ANY "YES" ANSWERS TO QUESTIONS 1-7.

Person's name	Details (Illness, injury or impairment, operation performed, hospitalization, medications, names & addresses of doctors, hospitals or clinics involved, other details)

It is agreed: (A) Reinstatement is based on statements in this application and in the original application and is contingent upon: (i) approval at BMA's Home Office; and (ii) payment of premium and interest as required by BMA. (B) All statements in this application are, to the best of my knowledge and belief, complete and true. (C) Any misstatements in this application may result in coverage being rescinded; and (D) If reinstatement is not approved, any amount paid will be refunded and any receipt previously issued will be void.

I authorize any physician or institution, including MIB, to give information to BMA concerning any person listed. (**Physician's are not to disclose the results of any HIV tests.)** I have received a copy of the MIB disclosure and Fair Credit Notice. I understand: (a) this authorization may be used to determine my insurability or to process a claim if incurred; (b) this authorization is valid for 26 months from the date below; (c) I and any authorized representative have the right to obtain a copy of this authorization on request; (d) I may revoke this authorization any time by written request, but that doing so may result in my application for insurance or claim being denied; and (e) failure to sign this authorization may impair our ability to process this application or evaluate a claim and may result in either coverage or the claim being denied.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim or provides false, incomplete, or misleading information as part of the information provided to obtain coverage commits a fraudulent act, which is a crime and may be subject to criminal and civil penalties.

_____	_____	_____
PROPOSED PRIMARY INSURED	COMPLETED AT CITY, STATE	DATE
_____	_____	_____
OTHER PROPOSED INSURED ADULT *(IF APPLICABLE)*	COMPLETED AT CITY, STATE	DATE
_____	_____	_____
PROPOSED OWNER *(IF OTHER THAN INSURED)*	COMPLETED AT CITY, STATE	DATE
_____	_____	_____
LICENSED REPRESENTATIVE	CODE	AGENCY