Western Reserve Life Assurance Co. of Ohio, P.O. Box 5068, Clearwater, Florida 33758

Application for Reinstatement and/or Policy Change

Policy Number:_____ **Insured Name** _____

If reinstatement is approved,the contestable period will start ane w. This application must be a ccompanied by all r equired premiums.

PART 1. PROPOSED INSURED(S) INFORMATION

	Last Name	M.I.	First name	Birth Date	Birth Place	Height Ft. in.	Weight Lbs.	Sex
Primary Insur ed								
Spouse or 1st OIR								
CIR or 2nd OIR								
CIR or 3rd OIR								
Telephone Number ( ) _____ Best time to call ☐ AM ☐ PM _____								

If additional space is necessary for CIR's, list child's name and date of birth on a separate sheet of paper.

PART 2. MEDICAL QUESTIONS

Has any proposed insured listed in Part 1

This authorization excludes disclosure of the results of a test for HIV if the applicant has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

1) Within the last 5 years been treated for or been told by a member of the medical profession that they had heart disease or circulatory problems,stroke, cancer, diabetes,kidney or liver disorder, lung or respiratory disorder, Alzheimer's Disease, mental or psychiatric disorder, alcohol or drug abuse? (Please circle the applicable ailments) YES☐ NO☐

2) Within the last 5 years consulted a medical practitioner? YES☐ NO☐

3) Within the last 5 years been diagnosed by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome)? **Answer this question NO if you have tested positive for HIV and have not developed symptoms of the disease AIDS.** YES☐ NO☐

4) Within the last 12 months used tobacco or other nicotine products in any form? YES☐ NO☐

Give details to all **YES** answers above. Please indicate person(s) to which details apply, dates of visit, reason for visit and findings. Give us the doctor, hospital, clinic, or health care providers full name and address.

Proposed Insured:	Proposed Insured:	Proposed Insured:
Question number:	Question number:	Question number:
Reason for visit:	Reason for visit:	Reason for visit:
Dates of visits:	Dates of visits:	Dates of visits:
Findings:	Findings:	Findings:
Dr./Clinics address:	Dr./Clinics address:	Dr./Clinics address:

Part 3. Occupation and Miscellaneous Questions

5) Has any proposed insured listed in Part 1 had a change in occupation or income since the original application? YES☐ NO☐
If yes, indicate whom and describe current occupation and income._____
_____

6) State occupation and income for any adult applicant listed in Part 1 to be added to policy:_____
_____

7) Has any proposed insured listed in Part 1 had their drivers license suspended, revoked, restricted, or been convicted of a moving violation in the last 12 months? YES☐ NO☐
If yes, provide Driver's License number, State of issue, and details. _____
_____

8) Does any proposed insured listed in Part 1 participate in aviation or any organized hazardous sport or activity? YES☐ NO☐
If yes, complete an aviation or hazardous sports questionnaire and attach to application.

9) Will any proposed insured listed in Part 1 travel outside the United States within the next 12 months? YES☐ NO☐
If yes, provide details of when, where,and length of time._____
_____

Part 4. Representations

I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief.
It is agreed that:

(a) The statements and answers given in this application, and any amendments or application supplements to it or statements made to the medical examiner, will be the basis of any reinstatement granted or insurance issued.
(b) No agent or medical examiner has the authority to make or alter any contract for the Company.
(c) No reinstatement will be effective or coverage provided until the date the application is approved by the company.
(d) If a premium deposit is given, no insurance shall take effect until the application is approved by the company while all persons shown in Part 1 are living and their health remains as stated in the reinstatement and policy change application.
(e) If a premium deposit is not given,no insurance shall take effect until the application is approved by the company and accepted by the owner, all premiums due have been paid and while all persons shown in Part 1 are living and their health remains as stated in the reinstatement and policy change application.
(f) I further agree that this application will be attached and shall be made a part of the contract for insurance.

Part 5. Authorization to Obtain Information

I authorize any physician, medical professional, hospital, clinic, other medical care institution, the Medical Information Bureau, Inc., insurance company, consumer reporting agency, or employer having information available as to employment,other insurance coverage, medical care, advice or treatment with respect to any physical or mental condition regarding me or any of my minor children who are to be insured, to give such information to Western Reserve Life Assurance Co. of Ohio, its reinsurers, or any consumer reporting agency except the Medical Information Bureau, acting on Western Reserve Life's behalf.

This authorization excludes disclosure of the results of a test for HIV if the applicant has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

I authorize Western Reserve Life Assurance Co. of Ohio to obtain an investigative consumer report on me and upon my request I am entitled to receive a free copy of this report.

I authorize Western Reserve Life Assurance Co. of Ohio to obtain a motor vehicle report on me.

I understand that this information will be used by Western Reserve Life or its reinsurers, to determine eligibility for life insurance.

I understand that failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

I agree that this authorization is valid for two and one-half years from the date signed. I know that I or my authorized representative have a right to receive a copy of this authorization upon request.I agree that a photographic copy of this authorization is as valid as the original.

I also hereby authorize Western Reserve Life Assurance Co. of Ohio to provide its affiliated companies any and all information provided herein and obtained hereafter on me. This authorization shall be valid from the date signed below until affirmatively revoked in writing by myself and that revocation may be a basis for denying insurance benefits.

☐ I elect not to have personal information disclosed to non-affiliates of Western Reserve Life Assurance Co. of Ohio for marketing purposes.

☐ I elect to be interviewed if an investigative consumer report is prepared in connection with this application.

FRAUD WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment,fines and denial of insurance benefits.

Signed at _____(city)_____ (state)_____ on _____(date)

_____ _____

Signature of Primary Insured or Proposed Insured (if over age 15 must sign)

Signature of Owner if other than proposed Insured

_____ _____

Signature of Spouse (if applicable)

Signature of Other Insured age 15 or over

_____ _____

Signature of Other Insured age 15 or over

Signature of Licensed Agent Agent #

Fair Credit Reporting Act

A routine investigative consumer report may possibly be made regarding your general reputation, character, mode of living and personal characteristics. This information may be obtained through personal interviews with your friends,neighbors and associates. Should you desire additional information on the nature and scope of such a report, you may write the Underwriting Department, Western Reserve Life Assurance Co. of Ohio, PO Box 9009, Clearwater, FL 33758. You may also request information concerning the nature and scope of the investigation to be performed.

The Medical Information Bureau Pre-Notice

The Medical Information Bureau ("MIB") is a non-profit organization of life insurance companies which operates as an information exchange for its members.

We may make reports to the MIB regarding factors affecting your insurability. Underwriting decisions,however, are not reported to the MIB. If you apply to another Bureau member company for life or health insurance or submit a claim for benefits, the MIB will, upon request, provide that company with information in its file.

Upon your written request,the MIB will arrange for disclosure to you of any information it has in your file. If you feel the information in the MIB's file is incorrect, you may contact the MIB and seek a correction in accordance with procedures outlined in the Federal Fair Credit Reporting Act. The address of the MIB's office is: MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112. MIB's telephone number: (617) 426-3660.

If you would like to know more about how we collect, evaluate and control information about you as one of our applicants for insurance, our sales representatives will be happy to assist you or you may contact us at our office.