



North American Company

for Life and Health Insurance

Principal Office: 4601 Westown Pkwy, Suite 300
West Des Moines, IA 50266

A Member of the Sammons Financial Group



L1772181

REINSTATEMENT APPLICATION

I hereby apply for reinstatement of Policy No. _____ and in connection make the following statements:

1. What is your occupation and duties? _____
2. Present height _____ weight _____.
3. Have you or any other covered individuals named in the policy:
 - (a) been advised to have a surgical operation?
If so, give details: _____
 - (b) consulted a physician or been hospitalized during the past five (5) years? If so, give details: _____
 - (c) been advised to take treatment for drug or alcohol use? If so, give details: _____

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits. I certify to the best of my knowledge and belief that I and all other covered individuals named in the policy are now in good health except as set forth in the above statements.

I understand and agree that: 1) no coverage shall become effective until this application is approved by the Company; 2) this application is offered to the Company as an inducement to grant insurance; and 3) that my answers to the above questions are true, full and complete to the best of my knowledge and belief; and 4) this reinstatement, if approved by the Company, shall be contestable to the same extent and for the period of time from the date of the approval of this reinstatement, as was the above described policy on and after its issuance.

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or 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 or of any member of my family, to give North American Company for Life and Health Insurance or its reinsurers any such information. This includes that information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application for insurance. To facilitate the rapid submission of such information, I authorized all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by North American Company for Life and Health Insurance to collect and transmit such information. A photographic copy of this authorization shall be as valid as the original. I have received the Disclosure of Information and Fair Credit Reporting Act notices.

Signed at _____ on _____ / _____ / _____
Month Day Year

Signature of Witness

Signature of Proposed Insured

Spouse (FPB Only)

Owner (if other than Proposed Insured)
Signature & title of officer signing for Corp. or trustee or pension



L1772182

MIB NOTICE OF DISCLOSURE OF INFORMATION

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

Information regarding your insurability will be treated as confidential except that North American Company for Life and Health Insurance may make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. On request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, the Bureau will supply such company with the information it may have in its files. The Company may also release information in its files to its reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

On receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Medical information will only be disclosed to your attending physician. If you question the accuracy of information in the Bureau's file you may seek 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 MA 02112, telephone 617/426-3660.

RETAIN THIS NOTICE FOR YOUR RECORDS

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S): Federal law requires you to be advised that in connection with your application for insurance, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted or who may have knowledge of any such information. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living. It is possible that a representative of a firm employed to make such reports may call on you in person. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.