



L17721CRT

Reinstatement Application

Life Insurance Certificate-Part A

Note: Complete the information and questions on this application on yourself, your spouse and children if they were also covered under the lapsed certificate.		1. Payment Submitted: \$ _____	2. Certificate Number: _____
3. Name of Insured: (Print full name) _____	4. Date of Birth: _____	5. Current Occupation: (Give title and duties) _____	
6. Current Home Address: _____	City/Town _____	State _____	Zip Code _____ Phone Number () _____
7. a. Your Height? _____ ft. _____ in. Weight? _____ lbs. b. Have you lost over 10lbs. in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, give details in #10) c. Name and address of your personal physician or health care facility: (if none, check here <input type="checkbox"/> and omit d., e. and f.) _____ d. Date last consulted? _____ e. Reason for consultation? _____ f. Was any medication or treatment prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe _____			
8. Since the date of the application of the lapsed certificate, have you or any other person covered under the lapsed certificate:			
a. Been diagnosed or treated by a medical professional for heart disease, stroke, cancer, brain or mental disease, AIDS or HIV infection, alcohol or drug addiction, or diabetes? _____			Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Consulted, been examined or treated by any medical professional, or been admitted to or treated at a hospital or other care facility for any disease or condition not indicated in question 7 or 8a. above? _____			<input type="checkbox"/> <input type="checkbox"/>
9. Have you or any other person covered under the lapsed certificate:			
a. Any life insurance applications pending with any other company? _____			Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Been refused life or health insurance or reinstatement of life or health insurance within the past 3 years? _____			<input type="checkbox"/> <input type="checkbox"/>
c. Been convicted in the past 3 years of a moving violation or driving under the influence of alcohol or drugs or had a drivers license suspended or revoked? (If Yes, give license no. and state in #10) _____			<input type="checkbox"/> <input type="checkbox"/>
d. In the past 3 years, flown as a pilot or crew member or in any capacity other than fare paying passenger, or intend to do so in the future? _____			<input type="checkbox"/> <input type="checkbox"/>
e. In the past 3 years, done any underwater diving, parachuting, sky diving, hang gliding, mountain climbing, cave exploration, vehicle racing of any kind or intend to do so in the future? _____			<input type="checkbox"/> <input type="checkbox"/>
f. Any intention of traveling or residing outside of the U. S. or Canada? _____			<input type="checkbox"/> <input type="checkbox"/>
g. Use tobacco in any form within the last 12 months? _____			<input type="checkbox"/> <input type="checkbox"/>

10. Remarks: Give full details to all **Yes** answers including the name of the covered person and question number: (Use reverse side if more space is needed.)

Agreement - I (We) agree that: (1) All covered individuals named in the certificate are now in good health except as set forth in this application; (2) All the statements and answers recorded on this application, including any required Part II, supplement or amendment are true and complete to the best of my (our) knowledge and belief and shall be the basis of any reinstatement granted; (3) That the certificate shall not be reinstated until the Company has received all premiums due and approved this application at its Home Office during the lifetime of the Insured; (4) That the terms and conditions of the incontestable provision of the certificate being reinstated shall apply to this application from the date the Company approved it.

Medical Authorization - To determine eligibility for insurance, I authorize: (1) any physician, medical practitioner, health care professional, hospital, clinic, or other medical or medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsuring company, viatical company, viatical broker or provider, the Medical Information Bureau, Inc., consumer reporting agency, insurance support organization, independent administrator, or pharmacy, governmental agency, group policyholder, employer or benefit plan administrator having information available as to diagnosis, prescription history, medications prescribed, treatment and prognosis with respect to information regarding alcoholism, drug abuse, and psychiatric care or any physical or mental condition and/or treatment of me or my minor children and financial, avocation, hazardous sports, aviation, driving, arrest, and credit information of me or my minor children, to give to North American Company for Life and Health Insurance ("the Company"), its representatives or reinsurers, any and all such data; (2) the Company to conduct a personal telephone interview in connection with my application; and (3) the Company to release any such data to its reinsurers, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, or as required by law when given a copy of this authorization. Data released may include results of my medical examination or tests requested by the Company. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report and that I am entitled to receive a copy of such report upon request. This authorization is valid for the time period required by the state where the application is written from the earlier of: (1) the date signed, or (2) the Certificate Date. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that I or any authorized representative will receive a copy of this authorization upon request.

Signed at _____ Date: _____
 (City and State)

Insured: _____ Spouse: (if covered) _____

Witness: _____ Owner: _____
 (if other than insured)

