



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



L1772ME

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: _____

4. Secondary Addressee Billing Notice for Lapse for Nonpayment of Premium: YES (Provide name, address, zip code) NO

***Answer these questions "NO", if you have tested positive for HIV but have not developed symptoms of the disease AIDS/ARC.**

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.

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 30 months from the earlier of: (1) the date signed, or (2) the Policy 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. Failure to sign an authorization statement or revoking it 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.

***This authorization excludes disclosure of the result 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.**

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 may include imprisonment, fines or a denial of insurance benefits.

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