U.S. FINANCIAL LIFE INSURANCE COMPANY
REQUEST FOR POLICY REINSTATEMENT FOR POLICY

POLICY OWNER

INSURED

HEIGHT WEIGHT

DATE OF BIRTH

SOCIAL SECURITY NO.

HOME PHONE

WORK PHONE

PLEASE NOTE ANY CHANGE OF ADDRESS ABOVE

IMPORTANT: ANSWER ALL THE QUESTIONS BELOW AND SIGN ON THE BOTTOM. PROVIDE DETAILS TO ANY "YES" ANSWERS IN THE SPACE PROVIDED. ATTACH AN ADDITIONAL SHEET IF NECESSARY.

	YES	NO
1, HAVE YOU USED TOBACCO IN ANY FORM IN THE PAST 12 MONTHS?	☐	☐
2. HAVE YOU EVER OR DO YOU ANTICIPATE IN THE NEXT TWO YEARS PARTICIPATION IN ANY FORM OF: racing, sky diving, underwater diving, parachuting, parasailing, racing of any vehicle, ... rock and/or mountian climbing, boxing, kayak competition, cave exploration, ice boating, ice climbing, ballooning, helicopter, skiing, or contact sports activities.	☐	☐

This section must be completed for all applications.

1) a) Proposed Insured: Height ft. in. Weight lbs. Weight loss in past year (lbs.)

b) Do you have a personal doctor? Yes No *(If Yes, write name, address, and telephone number below.)*

Name

Address Telephone

City State Zip

c) When was last visit and why? _____

Please answer all questions. *(To provide us with additional information, please use Medical Details section on page 2.)*

2) Has the Proposed Insured had, been treated for, or been told by a doctor as having: *(Circle conditions to which Yes applies and give details in the Medical Details Chart on page 2.)*	Proposed Insured *Yes*	Proposed Insured *No*	Children *Yes*	Children *No*
a) Convulsions, epilepsy, paralysis, mental, or nervous disorders?	☐	☐	☐	☐
b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?	☐	☐	☐	☐
c) Asthma, emphysema, bronchitis, tuberculosis, sleep apnea, or other disorder of lung or respiratory system?	☐	☐	☐	☐
d) Intestinal bleeding, chronic colitis, hepatitis, or other disorder of esophagus, stomach, intestines, liver, or pancreas?	☐	☐	☐	☐
e) Diabetes, anemia, or any disorder of glandular system or blood?	☐	☐	☐	☐
f) Disease of kidney or bladder—or sugar, blood or protein in urine?	☐	☐	☐	☐
g) Arthritis or any disorder of muscles or bones including spine or joints?	☐	☐	☐	☐
h) Cancer or tumor (any location)?	☐	☐	☐	☐
i) Any disorder of prostate or reproductive organs?	☐	☐	☐	☐
j) Any other medical condition not mentioned above?	☐	☐	☐	☐

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3) Has the Proposed Insured: *(Circle conditions to which Yes applies and give details in the Medical Details section below.)*	Proposed Insured *Yes*	Proposed Insured *No*	Children *Yes*	Children *No*
a) Other than above, had examination, testing, treatment, or consultation with a doctor, or been hospitalized during the past five years?	☐	☐	☐	☐
b) Been on, or are now on, any medication or prescribed diet?	☐	☐	☐	☐
c) Sought, or advised to seek treatment or advice, or been convicted for the use of drugs or alcohol?	☐	☐	☐	☐
d) Ever used narcotics, hallucinogens, barbiturates, heroin, marijuana, cocaine, or any other drug not prescribed by a physician?	☐	☐	☐	☐
e) Ever been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐
f) Ever received disability benefits?	☐	☐	☐	☐
g) Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed?	☐	☐	☐	☐
h) Had a parent, brother, or sister who had cancer, diabetes or heart disease? *(Please show age at onset and/or date of death.)*	☐	☐	☐	☐
i) In the last year, had any persistent known symptoms, conditions, or disorders not listed above?	☐	☐	☐	☐

NOTICE - ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Medical Details:

Person's Name	Question Number	Date of Onset	Diagnosis and and Treatment	Duration	Name, Address, and Telephone No. Attending Doctor and Hospital *(if applicable)*	Date Last Seen

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize any physician, medical professional, hospital, clinic, medical care institution, insurance company, Medical Information Bureau, consumer reporting agency, or employer that has any record or knowledge of me or my minor children or of our physical or mental health, medical care, treatment or advice, employment infomation or other insurance ovcerage to give any such information to the company indicated above or its reinsurers. All such sources, except the Medical Information Bureau, may give such information to any agency employed by the company to collect and transmit information. I also authorize the company listed above or its resinsurers to release any health or personal information regarding me or my minor children to the Medical Information Bureau and to other life insurance companies in which I may have policies or to whom I may apply.

I understand this information will be used to evaluate my (our) application for life insurance and that I have a right to receive a copy of this authorization upon request. I agree this authorization is valid for thirty months from the date signed and that a photographic copy of the authorization is as valid as the original. All of the answers provided are representations and not warranties.

Dated at _____ _____
city state signature of primary proposed insured
(or if below age 15, parent or legal guardian must sign)

Date _____ _____ _____
signature of witness signature of owner

FOR OFFICE USE ONLY
REINSTATEMENT APPROVED:
ON:
BY:

COMPLETE AND MAIL THIS FORM TO:
U.S. FINANCIAL LIFE INSURANCE COMPANY
P.O. BOX 4763
SYRACUSE, NEW YORK 13221-4763

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Authorization for Release of Health-Related Information to U.S. Financial Life Insurance Company

This authorization complies with the HIPAA Privacy Rule

_____ _____/____/_____

Name of proposed insured/patient (please print) Date of birth

I hereby authorize the release of information from all doctors and/or facilities, including the following:

_____

Name Address

_____

Name Address

_____

Name Address

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the U.S. Financial Life Insurance Company (U.S. Financial) and LabOne, Inc., its agents, employees, and representatives. LabOne, Inc. is obtaining this information on behalf of U.S. Financial Life Insurance Company (U.S. Financial) for the express purposes outlined in the third paragraph of this release. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that U.S. Financial may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with U.S. Financial.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation t o U.S. Financial at P.O. Box 4763, Syracuse, New York 13221-4763 Attention: Privacy Official. I understand that a revocation is not effective t o the extent that any of My Providers has relied on this Authorization or to the extent that U.S. Financial has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, U.S. Financial may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient