

**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?	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE YOU EVER OR DO YOU ANTICIPATE IN THE NEXT TWO YEARS PARTICIPATION:		
A. AS A PILOT OR MEMBER OF THE CREW OF ANY TYPE OF AIRCRAFT?	<input type="checkbox"/>	<input type="checkbox"/>
B. IN SKY DIVING, PARACHUTING, HANG GLIDING, AUTO RACING OR ANY OTHER HAZARDOUS SPORTS?	<input type="checkbox"/>	<input type="checkbox"/>

*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.)**

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

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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 Children			
	Yes	No	Yes	No
a) Other than above, had examination, testing, treatment, or consultation with a doctor, or been hospitalized during the past five years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Been on, or are now on, any medication or prescribed diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Sought, or advised to seek treatment or advice, or been convicted for the use of drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Ever used narcotics, hallucinogens, barbiturates, heroin, marijuana, cocaine, or any other drug not prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Ever received disability benefits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Had a parent, brother, or sister who had cancer, diabetes or heart disease? (Please show age at onset and/or date of death.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) In the last year, had any persistent symptoms, conditions, or disorders not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTICE - ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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

### 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 of our physical or mental health, medical care, treatment or advice, employment information or other insurance coverage 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 reinsurers 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 a valid as the original.

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

NJ REINSTATEMENT1 (11/05)

**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 to U.S. Financial at 10290 Alliance Road, Cincinnati, OH 45242 Attention: Privacy Official. I understand that a revocation is not effective to 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

**Financial Supplement II Forming Part of the Application for Life Insurance** (Complete if the Proposed Insured is age 65 or older and the sum of the Face Amount of all applications for life insurance that will be underwritten concurrently with AXA Equitable, and/or any other affiliated company, equals \$2 million or more.) If additional space is needed to complete this application, attach additional sheet of paper; it must be signed and dated by the Proposed Owner, Proposed Insured, and Financial Professional.

\_\_\_\_\_  
Name  Proposed Insured/  Additional/Joint Insured

\_\_\_\_\_  
Owner name if other than Proposed/Additional Insured

1. What is the planned source of funding for the policy(ies) currently applied for? (Please provide details of funding, including name(s) of all entities involved. If the source of funding is from a life insurance policy, include the name of each company and number of years policy in effect.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Has any party, other than the Proposed Owner or Proposed Insured, provided or offered to provide funding, either now or in the future, for any premium payment for the policy? (If "Yes", please provide details of the funding, including the names of all entities involved.) \_\_\_\_\_  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

3 a. Are either the Proposed Owner or Proposed Insured now financing or intending to finance any of the premium payments required to pay for and/or to maintain this policy through a financing or loan agreement? (If "Yes", submit a copy of the financing or loan agreement, detailed Personal Financial Statement signed by the preparer, and complete below.)  Yes  No

Loan \_\_\_\_\_ (% of premium) Identify Source of Loan \_\_\_\_\_

Loan Repayment Schedule (If the loan can be extended, include duration for which loan may be extended) \_\_\_\_\_

Describe the collateral used \_\_\_\_\_

b. Is the Proposed Owner or Proposed Insured required to post a letter of credit or personal guarantee?  Yes  No  
(If "Yes", please describe details of asset(s) or financial institution offering the guarantee.)

Interest rate \_\_\_\_\_ % Frequency \_\_\_\_\_ Duration \_\_\_\_\_

c. If interest may be accrued, give details \_\_\_\_\_

d. In addition to repayment of principal and interest, are there other fees, charges, or other consideration to be paid on maturity?  Yes  No  
(If "Yes", give details of additional fees, charges, or consideration) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Other Financing Agreement

If the Proposed Owner or Proposed Insured will be paying premiums funded by an individual and/or an entity other than the Proposed Insured(s), or the Proposed Insured's employer, provide details of the arrangement together with any documents relating to the arrangement:

Description \_\_\_\_\_ Interest rate \_\_\_\_\_ % Frequency \_\_\_\_\_ Duration \_\_\_\_\_

Additional fees, charges, or consideration \_\_\_\_\_

5. Are the Proposed Owner, Proposed Insured, or any person or entity, either being paid or offered: cash, services, or any other consideration, as an inducement (a) to enter into this transaction or (b) for the transfer of any beneficial interest in the proceeds of the policy? (If "Yes", describe in detail.) \_\_\_\_\_  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

6. Will any entity, other than a life insurance company, be medically evaluating the Proposed Insured to determine life expectancy, or otherwise provide financing? (If "Yes", give details, including the name(s) of the entity(ies)) \_\_\_\_\_  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

**References (Personal and/or Business)**

Attorney:	Name	Business Address	Telephone No.
Accountant:	Name	Business Address	Telephone No.
Other:	Name	Branch	Title of Account
	Name	Branch	Title of Account
Have bankers, attorneys and accountants been authorized to release information?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "no", explain _____			
I represent that the statements and answers in this Supplement, and in any supporting documentation provided by me for use in conjunction with this Supplement, are true and complete to the best of my knowledge and belief.			
Signature of Proposed Insured/Additional Joint Insured		Date	
Signature of Owner if other than Insured			
Signature of Licensed Financial Professional/Insurance Broker			