

**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 Part II Special Requests and Remarks section.)

	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"/>

NM REINSTATEMENT1 (11/05)

NEW MEXICO NOTICE OF CONFIDENTIAL DOMESTIC ABUSE INFORMATION PRACTICES NOTICE

The laws of your state provide protections for victims of domestic abuse. To comply with those requirements, we are required to provide you with this Notice of our legal duties regarding confidential abuse information received and collected by us in connection with certain insurance actions. This does not mean that our records reflect that you or any member of your family is or has been a victim of domestic abuse. Please review this notice carefully and retain it for your records.

We may receive and collect Confidential Abuse Information from persons other than a Protected Person. In the course of collecting information for applications or claims, we may receive confidential abuse information. Confidential abuse information means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. The information may be received from persons other than a victim of domestic abuse. Sources include, but are not limited to, medical records, police reports, interviews and insurance support agencies. We will not use confidential abuse status to deny, refuse to issue, renew or reissue coverage, or to cancel or otherwise terminate a policy. We will not use such information to restrict or exclude coverage or benefits of a policy or to charge a higher premium.

What is a Protected Person. A Protected Person is: (1) a victim of domestic abuse who has notified an insurer that he or she is or has been a victim of domestic abuse and who: (a) is a present or proposed principal insured; (b) is a present or proposed policy-owner; (c) is a present applicant; (d) is a present claimant; (e) derives or is proposed to derive insurance coverage under an insurance policy subject to this rule; or (2) an individual or entity that provides shelter, advocacy, counseling, or protection to victims of domestic abuse. **If you would like to be treated as a Protected Person, you must notify us of your request to be considered a Protected Person as indicated below.**

Disclosures and Uses of Confidential Abuse Information Without Your Authorization.

- We will disclose confidential abuse information to a victim or to an individual specifically designated in writing by the victim, and nothing in this section prohibits a victim of domestic abuse from obtaining the victim's own insurance records.
- We will disclose confidential abuse information to a health care provider for the direct provision of health care services.
- We will disclose confidential abuse information to a licensed physician identified and designated by the victim of domestic abuse.
- We will disclose confidential abuse information pursuant to an order of the Superintendent of Insurance or a court of competent jurisdiction, or as otherwise required by law.
- We will disclose confidential abuse information when necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship or that is relevant to processing a claim, provided the recipient has agreed to be bound by the provisions of the New Mexico Domestic Abuse Insurance Protection Act in all respects and to be subject to enforcement of that act in the courts of New Mexico, and the information is disclosed or transferred only: (1) to a reinsurer that seeks to indemnify or indemnifies all or part of a policy covering a victim of domestic abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without the information; (2) to a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer; (3) to medical or claims personnel contracting with the insurer, its parent or affiliated companies that have service agreements with the insurer, but only when necessary to process an application or claim, perform the insurer's duties under the policy or protect the safety or privacy of a victim of domestic abuse; or (4) with respect to address and telephone number, to entities with which the insurer transacts business when the business cannot be transacted without the address or telephone number.
- We will disclose confidential abuse information to an attorney who needs the information to represent

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the insurer effectively, provided the insurer notifies the attorney of its obligations under the New Mexico Domestic Abuse Insurance Protection Act and requires that the attorney exercise due diligence to protect confidential abuse information consistent with the attorney's obligation to represent the insurer.

- We will disclose confidential abuse information to the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status.
- We will disclose confidential abuse information to any other entities deemed appropriate by the Superintendent of Insurance.

Confidential abuse information used by an insurance support organization to prepare a report to us may be retained by the insurance support organization but, except as permitted by law, may not be disclosed to others without the written consent of the abuse victim.

Your Right to Protect the Confidentiality of Your Address. Upon notice to us, as set forth below, we will protect your address as Confidential Information that will not be disclosed to others.

Right to Your Confidential Abuse Information. Upon written request, you have the right to access the confidential abuse information that we may maintain about you in our records.

We will, within thirty (30) business days from the date such request is received:

- inform the abuse victim of the nature and substance of such confidential abuse information;
- permit the abuse victim to see and copy, in person, such confidential abuse information or to obtain a copy of such confidential abuse information by mail;
- provide an accurate plain language translation of any such confidential abuse information that is in coded form;
- disclose to the abuse victim the identity, if recorded, of those persons to whom we have disclosed such confidential abuse information within two (2) years prior to such request, and if the identity is not recorded, the names of those insurers and insurance support organizations or other persons to whom such information is normally disclosed; and
- provide the abuse victim with a summary of the procedures by which he or she may request correction, amendment or deletion of confidential abuse information.

If you believe that the confidential abuse information is incorrect or incomplete, you can make a written request to us to correct, amend or delete that information. We can deny your request for certain limited reasons, but we must give you a written basis for our denial. If we correct, amend or delete confidential abuse information, we will notify you and furnish the correction, amendment or fact of deletion to such persons or entities as required by law. If we refuse to correct, amend or delete confidential abuse information, the abuse victim may file with us a concise statement setting forth what he or she thinks is the correct, relevant or fair confidential abuse information and the reasons why he or she disagrees with our refusal to correct, amend or delete the information. We will retain the statement and provide it to anyone later reviewing the confidential abuse information.

How to Use Your Rights Under This Notice. If you want to use your rights under this Notice, that is, if you want to become a "Protected Person" or if you wish to request that we communicate with you using a confidential address you may write to:

U.S. Financial Life Insurance Company
P.O. Box 4763
Syracuse, New York 13221-4763
Attention: Privacy Officer

You can also call us at 1-800-959-3894 and ask for our Privacy Officer.

