

**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		
2) Has the Proposed Insured had, been treated for, or been told by a doctor as having:		Insured	Children	
<i>(Circle conditions to which Yes applies and give details in the Medical Details section on page 2.)</i>		Yes	No	Yes No
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"/>

VT REINSTATEMENT1 (11/05)

<p>3) Has the Proposed Insured: (Circle conditions to which Yes applies and give details in the Medical Details section below.)</p> <p>a) Other than above, had examination, testing, treatment, or consultation with a doctor, or been hospitalized during the past five years?</p> <p>b) Been on, or are now on, any medication or prescribed diet?.....</p> <p>c) Sought, or advised to seek treatment or advice, or been convicted for the use of drugs or alcohol?.....</p> <p>d) Ever used narcotics, hallucinogens, barbiturates, heroin, marijuana, cocaine, or any other drug not prescribed by a physician?</p> <p>e) Ever been treated for or diagnosed by a licensed medical doctor as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?</p> <p>f) Ever received disability benefits?</p> <p>g) Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed (except for disorders related to HIV antibody, T-cell counts, AIDS, or ARC)?</p> <p>h) Had a parent, brother, or sister who had cancer, diabetes or heart disease?</p> <p>(Please show age at onset and/or date of death.)</p> <p>i) In the last year, had any persistent symptoms, conditions, or disorders not listed above?</p>	<p>Proposed Insured Children Yes No Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>NOTICE - ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AS INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.</p>	

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

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 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 24 months from the date signed and that a photographic copy of the authorization is as valid as the original.

This authorization to release this information excludes the release of any information related to previously administered test for HIV antibodies, T-cell counts, AIDS or ARC by my regular medical practitioner or caregiver, or any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, U.S. Veterans Administration, the MIB, Inc., employer, consumer reporting agency, other insurance company, or anyone else who may be possesses of this information.

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

VT REINSTATEMENT1 (11/05)

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			