

# APPLICATION FOR REINSTATEMENT AND/OR POLICY CHANGE

**INSTRUCTIONS:** Use for a policy insuring one person only and lapsed more than 60 days.

1. Policy Number | 2. Policyowner | 3. Life Insured - if other than Policyowner

4. The Policyowner applies for (Note - Check off one or both of the following boxes):
- REINSTATEMENT** of a policy (a) lapsed, or (b) changed automatically to Extended Term Insurance or Reduced Paid-Up Insurance because of non-payment of a premium.
- A POLICY CHANGE** (Describe Fully)

5. For policy changes only:
- (a) Other than this policy, has the Life Insured any insurance in this Company which (i) has been issued or lapsed within the past year (ii) will be lapsed or changed if this change is approved?  Yes  No  
 If Yes, show policy number(s): \_\_\_\_\_
- (b) Will the change applied for replace any existing insurance or annuities?  Yes  No  
 If Yes, comply with existing replacement regulations.

6. Present Occupation - Give exact duties	7. Height ____ ft ____ ins	8. Weight _____ lb.	9. Any weight change in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason <input type="checkbox"/> Gain <input type="checkbox"/> Loss _____ lb.
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10. State total amount of insurance in all companies.

	LIFE INSURANCE (INCLUDE TERM RIDERS)	ACCIDENTAL DEATH	GPO
In force			
Pending			

- |   |   |
|---|---|
| 11. Have you:   | <b>Yes No</b>                                     |
| (a) i. Flown as a pilot, student pilot or crew member within the past five years?   | <input type="checkbox"/> <input type="checkbox"/> |
| ii. Any intention of doing so?  | <input type="checkbox"/> <input type="checkbox"/> |
| If either answered Yes, submit Aviation questionnaire.  |   |
| (b) i. Ever engaged in auto racing, motorcycle racing, parachuting, skydiving, hang gliding, underwater diving, ballooning, rodeos as a participant, mountain climbing or motorboat racing? | <input type="checkbox"/> <input type="checkbox"/> |
| ii. Any intention of doing so?  | <input type="checkbox"/> <input type="checkbox"/> |
| If either answered Yes, submit appropriate questionnaire.   |   |
| (c) i. Had a driver's licence suspended or revoked within the past 5 years?   | <input type="checkbox"/> <input type="checkbox"/> |
| ii. Been convicted of drunk or impaired driving within the past 5 years?  | <input type="checkbox"/> <input type="checkbox"/> |
| iii. Had more than 3 moving violations within the past 3 years?   | <input type="checkbox"/> <input type="checkbox"/> |
| If any of the above answered yes, provide driver's licence no. _____  |   |
| 12. (a) Have you smoked cigarettes within the past 12 months?   | <input type="checkbox"/> <input type="checkbox"/> |
| (b) If currently smoking, state the number of cigarettes smoked per day _____   |   |
| 13. Have you had a request for life or disability insurance declined, postponed, rated or restricted in any way?  | <input type="checkbox"/> <input type="checkbox"/> |

Particulars Of Yes answers.

**APPLICATION FOR REINSTATEMENT AND/OR POLICY CHANGE - continued**

	Yes	No
14. Has any member of your family suffered from diabetes, cancer, high blood pressure, heart or kidney disease or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever received counselling or treatment regarding the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
16. Since the date of the original application, have you:		
i. Had or been told you have any disease, illness, injury or disability?	<input type="checkbox"/>	<input type="checkbox"/>
ii. Consulted, been examined or treated by any doctor, practitioner, hospital or other institution not previously mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
iii. Had an electrocardiogram, x-ray or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
iv. Been advised to have any diagnostic test, hospitalization or surgery which has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>

Details of Yes answers: Identify question no., circle applicable terms, include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities.

**I DECLARE** that, to the best of my knowledge and belief, the statements and answers in this application and in the original application for the above policy, are full, complete and true.

It is agreed that:

1. This application and the statements and answers in any statement of health or questionnaire completed in connection with this application, shall be the basis of the reinstatement and/or policy change.
2. The reinstatement and/or policy change will be effective if:
  - (a) A Certificate of Reinstatement or any policy changed as requested in this application has been delivered to and accepted by the Policyowner.
  - (b) Any overdue or additional premium has been paid.
  - (c) All statements made at the time of this application are still true on the date the Certificate of Reinstatement or the changed policy is delivered and accepted.
3. If within, two years of the date of acceptance referred to in 2(a) above, any of the statements and answers contained in this application are found to be untrue, the policy change or reinstated policy may be declared void by the Company.

I have received the Notice Regarding the Medical Information Bureau. I have been notified that a consumer report may be prepared in connection with this application. I give permission to Crown Life Insurance Company, or its reinsurer(s) to obtain such a consumer report.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_

\_\_\_\_\_  
Policyowner

\_\_\_\_\_  
Life Insured (if other than Policyowner)

Policy Change - The beneficiary hereby consents to the above policy change.

\_\_\_\_\_  
Other Persons having an interest in the Policy

**AUTHORIZATION TO OBTAIN INFORMATION REGARDING  
APPLICATION FOR INSURANCE (DO NOT DETACH)**

**I AUTHORIZE** any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., or consumer reporting agency, having information available as to diagnosis, treatment and prognosis, with respect to any physical or mental condition and/or treatment of me, and any non-medical information of me, to give to Crown Life Insurance Company, or its legal representative, any and all such

**I UNDERSTAND** the information obtained by use of the Authorization will be used by Crown Life Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Crown Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required

**I KNOW** that I may request to receive a copy of this Authorization.

**I AGREE** that a photocopy of this Authorization shall be as valid as the original.

**I AGREE** this Authorization shall be valid for two and one half years from the date shown below.

Dated this \_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

**This authorization is not to be used if your state has adopted the Insurance information and Privacy Protection Act. Complete instead the Authorization in the Notice of Insurance Information Practices.**

**NOTICE REGARDING CONSUMER REPORT**

**PLEASE READ CAREFULLY**

We, or our reinsurer(s), may require a consumer report to be prepared as part of the normal procedure for processing this application. Such report will include information about your character, general reputation, personal characteristics and lifestyle. We will obtain this information through personal interviews with your neighbors, friends and acquaintances. If you would like more details about the nature of this report, you may write, within a reasonable period of time, to: The Underwriting Department, Crown Life Insurance Company, Serviced At: P.O. Box 1927, Buffalo, NY 14240-1927.

**NOTICE REGARDING THE MEDICAL INFORMATION BUREAU**

We will treat any information about your insurability as confidential. However, we, or our reinsurer(s), may make a brief report to the Medical Information Bureau. The Bureau is a non-profit organization of life insurance companies which provides an exchange of information service for its members. If you apply for life or health insurance, or if you submit a claim to another member company, the Bureau, upon request, will give any information in its files to such company.

We, or our reinsurer(s), may also release information from our files to other insurance companies to whom you apply for coverage or submit a claim for benefits.

You may request that the Bureau disclose any information it may have in your file. (Medical information will be released only to your physician). You may ask the Bureau to correct any information in your file which you feel is not accurate. The procedure to follow is outlined in the Fair Credit Reporting Act. The address of the Medical Information Bureau is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Phone: (617) 426-3660.

**TO BE LEFT WITH THE PROPOSED INSURED**