

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
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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 <input type="checkbox"/> Gain <input type="checkbox"/> Loss _____ lb. Reason _____
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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:	Yes No
(a) i. Flown as a pilot, student pilot or crew member within the past five years? ii. Any intention of doing so? If either answered Yes, submit Aviation questionnaire.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(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? ii. Any intention of doing so? If either answered Yes, submit appropriate questionnaire.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
(c) i. Had a driver's licence suspended or revoked within the past 5 years? ii. Been convicted of drunk or impaired driving within the past 5 years? iii. Had more than 3 moving violations within the past 3 years? If any of the above answered yes, provide driver's licence no. _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
12. (a) Have you smoked cigarettes within the past 12 months? (b) If currently smoking, state the number of cigarettes smoked per day _____	<input type="checkbox"/> <input type="checkbox"/>
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 the Life Insured dies by suicide within two years of the date of acceptance referred to in 2(a) above, the Company's only liability as a result of the policy change will be a return of any premiums paid since the date of acceptance.
4. The validity of the reinstatement and/or policy change may be contested if, within two years of the date of acceptance referred to in 2(a) above, any of the statements or answers contained in this application are found to be untrue.

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