

**SUPPLEMENT TO
APPLICATION FOR INSURANCE**

This form is to be completed in all cases at the time of application, as a supplement to the Application for Insurance - Part 2 or Medical Part 2. NOTE: Questions apply only to the 10 year period immediately preceding the date of application.

1. Proposed Insured (Please print)

Yes No

- | | | |
|--|--------------------------|--------------------------|
| 1. Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome, or AIDS Related Complex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome, or AIDS Related Complex? | <input type="checkbox"/> | <input type="checkbox"/> |

Details of Yes answers: Include diagnoses, dates, names and addresses of all physicians and medical facilities below:

I AUTHORIZE any physician, medical practitioner, hospital or other medical-care facility, the Medical Information Bureau, Inc., any insurance or reinsuring company, consumer reporting agency or my employer; to give to Crown Life Insurance Company its authorized representatives or consumer reporting agency, any information about me regarding:

- (1) diagnosis, treatment, advice or medical care of any physical or mental condition;
- (2) any use of drugs or alcohol;
- (3) any non-medical information.

I KNOW that an investigative consumer report may be prepared in connection with my application.

I elect to be interviewed if such a report is prepared.

Yes No

I KNOW that Crown Life Insurance Company, or its reinsurer(s), may make a brief report on me to other insurance companies to whom I applied or may apply for insurance.

I AGREE that this Authorization will be valid for two and one half years from the date shown below. A photocopy of this Authorization will be as valid as the original.

I KNOW that I may request to receive a copy of this Authorization. I have received copies of the Notice Regarding the Medical Information Bureau and the Fair Credit Reporting Act, and the Notice of Insurance Information Practices.

I waive in my name, and that of any other person who shall have or claim an interest in any policy issued as a result of the answers, all provisions of law forbidding such action.

To the best of my knowledge and belief, the answers and statements contained in this supplement are full, complete and true. I understand they will become part of the Application for Insurance.

Dated at _____ this _____ day of _____ year

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Signature of Proposed Life Insured

X

Signature of Witness

X

I AUTHORIZE Crown Life Insurance Company its authorized representatives and insurance support organizations, to obtain any medical and non-medical information required to evaluate my application for insurance.

If preferred, you may complete this supplement in private and mail it directly to: The Chief Medical Director, Crown Life Insurance Company, Serviced At: P.O. Box 1927, Buffalo, NY 14240-1927