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Policy Number	Date Lapsed	Premium Overdue

Your policy has lapsed or has automatically been continued as Reduced Paid-Up or Extended Term Insurance because of non-payment of the premium. However, you have a valuable reinstatement provision in your contract, and we strongly urge you to take advantage of it.

The Short Health Statement on the reverse side has been specially designed for use WITHIN 60 DAYS FROM THE DATE OF LAPSE - ACT NOW.

Please complete the form noting any exceptions. Date it and have it signed by the Proposed Insured, and return it with your payment of the overdue premium. Mail this application in the envelope provided, and we will give it our immediate attention.

If you are unable to pay the full amount at this time, please let us know. It is possible that we can adjust your policy to provide for more convenient premium payments.

SHORT HEALTH STATEMENT

Application for Reinstatement if life or health policy has lapsed 60 days or less.

Policy Number	Policyowner
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Since the date of the original application, has the Proposed Insured for coverage under this policy:

	Yes	No
1. suffered injury, disability or illness of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
2. consulted, been examined or treated by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
3. changed occupation or occupational duties?	<input type="checkbox"/>	<input type="checkbox"/>
4. applied for life or disability insurance to another company?	<input type="checkbox"/>	<input type="checkbox"/>
5. had a request for life or disability insurance declined, rated or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>

I am applying to the Company for Reinstatement of the above noted policy.

The statements and answers in the application for the above noted policy and in this application, are complete and true as of today's date.

If there are any exceptions to the above statements, full details must be given in the space below. Any exceptions stated below will be reviewed by the Company before any coverage takes effect.

EXCEPTIONS

Statement No.	Person to whom exception applies	Details (Include nature of illness or injury, dates, treatment, result, doctor's name and address, hospital, details of items 3 and 4 above.)

To the best of my knowledge and belief, the statements and answers represented 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, will form the basis for reinstatement.
2. The reinstatement will be effective if:
 - (a) A Certificate of Reinstatement 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 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 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

Other persons to be insured if age 21 or over

**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

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

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.