[The Chesapeake Life Insurance Company]

[Customer Service Address: 100 Centerview Drive, Suite 100, Nashville, Tennessee 37214]
[Customer Service: 1.866.215.5343]

APPLICATION FOR REINSTATEMENT OF INDIVIDUAL LIFE INSURANCE POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

Policy# : _____

Best Time to Call: Day_____ Time _____ ☐ AM ☐ PM ☐ Home ☐ Cell

SECTION [1] – DEMOGRAPHICS

Applicant Name: _____ State of Birth:_____
First Last MI

Sex: ☐ M ☐ F Date of Birth:____/___/_____ Age:_____ Birth Country (if not in the U.S.)_____

Social Security No. or Tax ID:_____ Occupation:_____

Applicant's Home Address: _____ Height:_____ Weight:_____

City:_____ State:_____ Zip: _____ County:_____

Daytime Phone: (____) _____-_____ Home Phone: (____) _____-_____

Cell Phone: (____) _____-_____ Fax Number: (____) _____-_____

Email Address: _____

Has Applicant been declined or postponed for Life or Health Insurance within the last 5 years? ☐ Yes ☐No

UNDERWRITING CLASS: Any form of nicotine use within last 12 Months? ☐Yes ☐No

SECTION [2] - BILLING INFORMATION

Billing / Mode:
☐ Monthly Bank Draft (Auth Required) ☐ Quarterly
☐ Semi-Annually ☐ Annually

SECTION [3] – APPLICANT HISTORY

I

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED "YES", COVERAGE WILL NOT BE REINSTATED.

1. Has Applicant *EVER* been diagnosed or treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

2. Within the last five years has Applicant had or been advised by a Physician to have any testing or any treatment which has not yet occurred, for which results are still pending, and/or that requires follow-up that has not been completed? ☐ Yes ☐ No

3. Has the Applicant been confined in a hospital or nursing home within the previous 90 days; or within the last 5 years:
   a. received medical advice or treatment for Alzheimer's Disease or Dementia, or been prescribed, by a licensed member of the medical profession, or taken Aricept (Donepezil), Reminyl, Razadyne (Galantamine), Cognex, Namenda or Excelon (Rivastigmine); or ☐ Yes ☐ No
   b. required human assistance of any kind to perform activities of daily living (bathing, dressing, continence, eating, or using the toilet)? ☐ Yes ☐ No

4. Has Applicant had, or been medically advised to have, an organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months? ☐ Yes ☐ No

5. Has Applicant, been diagnosed with, received medical advice to be tested, hospitalized or treated, or been treated by a member of the medical profession for *any* of the following:

(a) Cholesterol/Blood Pressure: Uncontrolled Cholesterol (total Cholesterol greater than 240 or Triglycerides greater than 325), or Uncontrolled Blood Pressure (a Systolic reading greater than 150 or Diastolic reading greater than 95), *WITHIN THE LAST 6 MONTHS*?	☐ Yes ☐ No	(e) Endocrine System: Diabetes prior to age 20, or taken Insulin Injections prior to age 40 or been treated for Insulin Shock, Diabetic Coma or Hospitalized 2 or more times for Diabetic Complications *WITHIN THE LAST 3 YEARS?*	☐ Yes ☐ No
(b) Mental Diseases or Disorders: Bipolar Disorder, Schizophrenia, Major Depressive Disorder, Manic Disorder, Alcoholism, Alcohol Abuse, Drug Abuse or Drug Addiction, *WITHIN THE LAST 5 YEARS*?	☐ Yes ☐ No	(f) Respiratory System: Chronic Obstructive Pulmonary or Lung Disease (COPD/COLD), Emphysema, Chronic Bronchitis, Respiratory Failure, Cystic Fibrosis, or required oxygen to assist in breathing, *WITHIN THE LAST 5 YEARS*?	☐ Yes ☐ No
(c) Heart and Circulatory System: Coronary Artery Disease, Heart Attack, Heart Surgery (including Angioplasty and Stent Placement), Congestive Heart Failure, Cardiomyopathy, Pacemaker Insertion, Heart Valve Replacement, or Aneurysm, Stroke (CVA), Transient Ischemic Attack (TIA), or had any procedure to improve circulation to the heart, brain or extremities, *WITHIN THE LAST 5 YEARS OR PRIOR TO AGE 50*?	☐ Yes ☐ No	(g) Nervous System: Multiple Sclerosis, Huntington's Disease, Muscular Dystrophy, Guillain-Barre Syndrome, Paralysis, Parkinson's Disease or Traumatic Brain Injury, *WITHIN THE LAST 5 YEARS*?	☐ Yes ☐ No
		(h) Connective Tissue Disease or Disorder: Systemic Lupus (SLE), *WITHIN THE LAST 5 YEARS*?	☐ Yes ☐ No
(d) Renal System and Liver: End Stage Kidney Disease, Renal Insufficiency, Chronic Renal Failure (including dialysis); Liver Failure, Cirrhosis, or Chronic Hepatitis (excluding type A), *WITHIN THE LAST 5 YEARS?*	☐ Yes ☐ No	(i) Cancer or Tumors: Melanoma, Breast Cancer, Prostate Cancer, Colon Cancer, Hodgkin's Disease, Non-Hodgkin's Lymphoma, Leukemia, or other malignant growths or tumors, *WITHIN THE LAST 5 YEARS*?	☐ Yes ☐ No

6. Has Applicant ever pled guilty to or been convicted of a felony, or within the last 3 years has Applicant been convicted of reckless driving or operating a motor vehicle while intoxicated or under the influence of drugs or alcohol? ☐ Yes ☐ No

SECTION [4] - FAMILY HISTORY (APPLICANT COMPLETE ONLY IF APPLYING FOR CRITICAL CONDITION ALBR)

7. Does Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have been diagnosed by the medical profession for any form of cancer (other than skin cancer) prior to age 65? ☐ Yes ☐ No

8. Does Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have been diagnosed by the medical profession for Heart Disease, Stroke, Diabetes (type I), Kidney Disease, Liver Disease, Alzheimer's or Dementia prior to age 65? ☐ Yes ☐ No

SECTION [5] - ACKNOWLEDGEMENTS, DECLARATIONS AND AGREEMENTS

I agree that: (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) no agent has the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage; *(d)* no insurance will be in force unless and until the amount required by the Company to reinstate the Policy has been paid in full and/or honored by my financial institution, and the Application is approved by the Company during the Applicant's lifetime.

I understand that the information in this Application will be relied upon to determine insurability and underwriting class, and that incorrect information may result in coverage being contested, subject to the Policy Incontestability provision.

I have received and understand the Description of Information Practices, Notice Concerning the Medical Information Bureau, Notification of Consumer Report and other consumer reports.

INSURANCE FRAUD WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

Signed _____/_____/_____ at _____, _____

Date City State

X_____ X_____

Signature of Owner (If other than Applicant) Signature of Applicant