APPLICATION FOR INDIVIDUAL LIFE INSURANCE - REINSTATEMENT

Surety Life Insurance Company, "The Company"

Fax or Mail to:
P.O. Box 660191
Dallas, TX 75266-0191
Phone: 1-800-525-9287
Fax 1-866-525-5433

☐☐☐☐☐☐☐☐☐☐

Policy Number

I (each undersigned) request that The Company reinstate this policy. I declare that all answers written herein are full and correct to the best of my knowledge and belief. Coverage will not start again until this request is approved by The Company and all required premiums and interest are paid. I understand and agree that the contestability period will begin again from the date of approval. If this request is not approved, any amount tendered will be returned.

A. OWNER - If other than Primary Insured

1. Full Name (First, Middle, Last) - If the Owner is a trust, provide full title of the trust and name(s) of current trustee(s).

2. Mailing Address

3. Primary Phone ☐Home ☐Cell ☐Work 4. E-mail Address

B. PRIMARY INSURED

1. Full Name (First, Middle, Last)

2. Mailing Address

3. SS / TIN Number ☐☐☐☐☐☐☐☐☐ 4. Birth Date (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

5. Primary Phone ☐Home ☐Work ☐Cell 6. E-mail Address

7a. Of what country are you a citizen? _____ If not a U.S. citizen, complete 7b. and 7c.

7b. When did you enter the U.S.? (MM/YYYY) _____

7c. Indicate type(s) of documentation you have: ☐Permanent Resident Card, number _____

☐Temporary visa, type* _____ ☐EAD (work permit), category* _____ * Submit copy

8. Primary Care Physician or Medical Provider Information (If none, state "NONE")

Physician's Name (First and Last) Phone Number

Physician's Address (include street, city, state, zip)

Date (MM/DD/YYYY) and Reason Last Consulted

Results of last consultation (including any diagnoses, test results, treatment, and referrals)

9. Weight:_____ lbs. Height: _____ Ft. _____ In.

10. Which best describes your usage of tobacco and nicotine products?

☐ Never used ☐ Used more than 5 years ago

☐ Currently Using ☐ Used in the last 5 years but not currently Provide date of last use: _____MM/YYYY

For current use and use in the last 12 months provide type(s) and quantity/frequency:

☐ Cigarettes	Quantity: _____	cigarettes per	☐ Day	☐ Month	☐ Year	
☐ Cigars	Quantity: _____	cigars per	☐ Day	☐ Month	☐ Year	
☐ Smokeless Tobacco	Frequency: _____	times per	☐ Day	☐ Month	☐ Year	
☐ E-Cigarettes, vape pen, or other Electronic Nicotine Delivery System	Frequency: _____	times per	☐ Day	☐ Month	☐ Year	
☐ Pipe	Frequency: _____	times per	☐ Day	☐ Month	☐ Year	
☐ Nicotine gum/patch	Frequency: _____	times per	☐ Day	☐ Month	☐ Year	
☐ Other _____	Frequency: _____	per	☐ Day	☐ Month	☐ Year	

11. In the last 5 years, have you used marijuana or THC in any form? ☐ Yes ☐ No

a. ☐ Recreational ☐ Medicinal

b. ☐ Smoked/Inhaled ☐ Eaten/Ingested ☐ Vaporized

c. Frequency: _____ per ☐ Day ☐ Month ☐ Year

d. Date of last use:_____MM/YYYY

C. ADDITIONAL/JOINT INSURED - Complete if you currently have an Additional/Joint Insured on your Policy. If more than one Additional Insured, submit additional copies of Section C.

1. Full Name (First, Middle, Last)

2. Mailing Address

☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐

3. SSN / TIN Number 4. Birth Date (MM/DD/YYYY)

_____ ☐ Home ☐ Work ☐ Cell _____

5. Primary Phone 6. E-mail Address

7a. Of what country are you a citizen? _____ If not a U.S. citizen, complete 7b. and 7c.

7b. When did you enter the U.S.? (MM/YYYY) _____

7c. Indicate type(s) of documentation you have: ☐ Permanent Resident Card, number _____

☐ Temporary visa, type* _____ ☐ EAD (work permit), category* _____ * Submit copy

8. Primary Care Physician or Medical Provider Information (If none, state "NONE")

Physician's Name (First and Last) Phone Number

Physician's Address (include street, city, state, zip)

Date (MM/DD/YYYY) and Reason Last Consulted

Results of last consultation (including any diagnoses, test results, treatment, and referrals)

9. Weight:_____ lbs. Height: _____ Ft. _____ In.

10. Which best describes your usage of tobacco and nicotine products?

☐ Never used ☐ Used more than 5 years ago

☐ Currently Using ☐ Used in the last 5 years but not currently Provide date of last use: _____MM/YYYY

For current use and use in the last 12 months provide type(s) and quantity/frequency:

☐ Cigarettes	Quantity: _____	cigarettes per	☐ Day	☐ Month	☐ Year
☐ Cigars	Quantity: _____	cigars per	☐ Day	☐ Month	☐ Year
☐ Smokeless Tobacco	Frequency: _____	times per	☐ Day	☐ Month	☐ Year
☐ E-Cigarettes, vape pen, or other Electronic Nicotine Delivery System	Frequency: _____	times per	☐ Day	☐ Month	☐ Year
☐ Pipe	Frequency: _____	times per	☐ Day	☐ Month	☐ Year
☐ Nicotine gum/patch	Frequency: _____	times per	☐ Day	☐ Month	☐ Year
☐ Other _____	Frequency: _____	per	☐ Day	☐ Month	☐ Year

11. In the last 5 years, have you used marijuana or THC in any form? ☐ Yes ☐ No

a. ☐ Recreational ☐ Medicinal

b. ☐ Smoked/Inhaled ☐ Eaten/Ingested ☐ Vaporized

c. Frequency: _____ per ☐ Day ☐ Month ☐ Year

d. Date of last use:_____MM/YYYY

D. CHILDREN FOR CHILDREN'S LEVEL TERM RIDER - Complete if you currently have the Children's Rider on your Policy.

☐ No children

1a. Child's Full Name (First, Middle, Last) 1b. Sex: ☐ M ☐ F

1c. Home Address (include street, city, state, zip) ☐ Same address and primary phone as Primary Insured

1d. SSN / TIN Number | 1e. Birth Date (MM/DD/YYYY) | 1f. Primary Phone ☐ Home ☐ Work ☐ Cell | 1g. Relationship to Primary Insured

2a. Child's Full Name (First, Middle, Last) 2b. Sex: ☐ M ☐ F

2c. Home Address (include street, city, state, zip) ☐ Same address and primary phone as Primary Insured

2d. SSN / TIN Number | 2e. Birth Date (MM/DD/YYYY) | 2f. Primary Phone ☐ Home ☐ Work ☐ Cell | 2g. Relationship to Primary Insured

3a. Child's Full Name (First, Middle, Last) | 3b. Sex: ☐ M ☐ F

3c. Home Address (include street, city, state, zip) | ☐ Same address and primary phone as Primary Insured

3d. SSN / TIN Number | 3e. Birth Date (MM/DD/YYYY) | 3f. Primary Phone | ☐ Home ☐ Work ☐ Cell | 3g. Relationship to Primary Insured

4a. Child's Full Name (First, Middle, Last) | 4b. Sex: ☐ M ☐ F

4c. Home Address (include street, city, state, zip) | ☐ Same address and primary phone as Primary Insured

4d. SSN / TIN Number | 4e. Birth Date (MM/DD/YYYY) | 4f. Primary Phone | ☐ Home ☐ Work ☐ Cell | 4g. Relationship to Primary Insured

5. Has any child proposed for reinstatement coverage:
   a. ever been diagnosed with, or received treatment or advice from a licensed member of the medical profession for: a congenital heart defect, other disorder of heart or blood vessels, epilepsy, cancer, leukemia, sickle cell anemia, diabetes, cystic fibrosis, asthma or other lung disorder, kidney disease, Attention Deficit Hyperactivity Disorder (ADHD), other psychiatric condition or disorder of brain or nervous system? ☐ Yes ☐ No
   b. been hospitalized since birth or had surgery for any abnormality or disorder not already disclosed? ☐ Yes ☐ No
6. Is any child proposed for reinstatement coverage currently taking prescribed medication on a regular basis or receiving ongoing therapy? ☐ Yes ☐ No

Details of "yes" answers (name of condition, dates, how treated, current status, name and address of physician):

E. GENERAL INFORMATION

Answer Questions 1 - 7 for all Primary, Additional and Joint Insureds. For any "yes" answers provide details in the table below.

	Primary Insured	Additional/ Joint Insured
1. To the best of your knowledge and belief, have you ever used: a. Cocaine, crack, heroin, ecstasy, PCP, LSD, methamphetamine or any other mind-altering drugs?	☐ Yes ☐ No	☐ Yes ☐ No
b. Amphetamines, barbiturates, sedatives, opioids, methadone or any controlled substance except as prescribed by a licensed member of the medical profession?	☐ Yes ☐ No	☐ Yes ☐ No
2. To the best of your knowledge and belief, in the last 10 years, have you plead guilty to or been convicted of a felony or misdemeanor or do you have any such charge pending against you?	☐ Yes ☐ No	☐ Yes ☐ No
3. To the best of your knowledge and belief, in the last 3 years, have you had more than one moving violation, had your license suspended or revoked, or been involved in any accident in which you were found to be at fault?	☐ Yes ☐ No	☐ Yes ☐ No
4. To the best of your knowledge and belief, in the last 5 years, have you been convicted of reckless driving, driving while impaired, driving while intoxicated or driving under the influence of alcohol or any drug?	☐ Yes ☐ No	☐ Yes ☐ No
5. To the best of your knowledge and belief, in the last 3 years, have you:		
a. flown as a pilot or crew member of any aircraft? (If "yes" submit applicable questionnaire.)	☐ Yes ☐ No	☐ Yes ☐ No
b. engaged in scuba diving, vehicle racing, mountain or rock climbing; or aerial sports, including skydiving, parachuting, BASE jumping, hang gliding, paragliding, wingsuit flying? (If "yes" submit any applicable questionnaire.)	☐ Yes ☐ No	☐ Yes ☐ No
6. To the best of your knowledge and belief, have you ever had an application for life insurance declined or rated substandard (i.e. extra premium charged)?	☐ Yes ☐ No	☐ Yes ☐ No
7. Do you plan to make your residence outside the U.S. in the next 2 years?	☐ Yes ☐ No	☐ Yes ☐ No

Details of "yes" answers for Questions 1-7:

F. HEALTH AND MEDICAL HISTORY

Answer Questions 1 - 7 for all Primary, Additional and Joint Insureds. For any "yes" answers, excluding Question 4, provide details in the table below.

	Primary Insured	Additional/ Joint Insured
1. To the best of your knowledge and belief, do you have a family history of heart disease, stroke or cancer beginning before age 60 in any natural parent or sibling? (If "yes," complete table below.)	☐ Yes ☐ No	☐ Yes ☐ No

Insured	Relative	Disease	Age at Onset	Age at Death	Cause of Death	Age if Living
	☐ Mother ☐ Brother ☐ Father ☐ Sister					
	☐ Mother ☐ Brother ☐ Father ☐ Sister					
	☐ Mother ☐ Brother ☐ Father ☐ Sister					

	Primary Insured	Additional/ Joint Insured
2. To the best of your knowledge and belief, have you ever been diagnosed, treated, or given advice by a licensed member of the medical profession for:		
a. High blood pressure, chest pain, a heart attack, coronary artery disease, heart murmur or valve disease, irregular heartbeat, heart enlargement or other disease of the heart?	☐ Yes ☐ No	☐ Yes ☐ No
b. Cerebrovascular disease, a stroke or mini stroke, aneurysm, blood clot or other disease of the blood vessels?	☐ Yes ☐ No	☐ Yes ☐ No
c. A polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma, Hodgkin's disease or any disease of the lymph nodes?	☐ Yes ☐ No	☐ Yes ☐ No
d. Diabetes, high blood sugar, glucose intolerance, or disease of the pituitary, thyroid or other endocrine gland?	☐ Yes ☐ No	☐ Yes ☐ No
3. To the best of your knowledge and belief, have you ever had or been advised by a licensed member of the medical profession to have treatment or counseling for alcohol or drug use or been advised to reduce or eliminate usage?	☐ Yes ☐ No	☐ Yes ☐ No
4. To the best of your knowledge and belief, have you ever been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐ Yes ☐ No	☐ Yes ☐ No

	Primary Insured	Additional/ Joint Insured
5. To the best of your knowledge and belief, within the last 10 years, have you been diagnosed, treated, or given advice by a licensed member of the medical profession for:		
a. A seizure, epilepsy, syncope or fainting, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or other disease of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
b. Anxiety, ADHD, depression, bipolar disease, PTSD, schizophrenia or other mental or psychiatric illness?	☐ Yes ☐ No	☐ Yes ☐ No
c. Asthma, emphysema, COPD, chronic bronchitis, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or other disease of the lungs or shortness of breath?	☐ Yes ☐ No	☐ Yes ☐ No
d. An ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, blood in stool, Crohn's disease, weight loss surgery or other disease of the esophagus, liver, stomach or intestines?	☐ Yes ☐ No	☐ Yes ☐ No
e. Anemia or other disease (excluding HIV) of blood, blood cells, blood clotting, or bone marrow?	☐ Yes ☐ No	☐ Yes ☐ No
f. Nephritis, polycystic kidney disease, blood in urine, or other disease of the bladder, kidney, urinary tract, prostate or other reproductive organs?	☐ Yes ☐ No	☐ Yes ☐ No
g. Arthritis, gout, back trouble, chronic pain syndrome, fibromyalgia, lupus, chronic fatigue syndrome, psoriasis or other autoimmune disease or disease of the skin, bones, joints or muscles?	☐ Yes ☐ No	☐ Yes ☐ No
6. To the best of your knowledge and belief, other than disclosed in response to previous questions, in the last 5 years have you:		
a. had a checkup, consultation, hospitalization, illness, surgery or medical or diagnostic test, including any self-administered or home test? (Do not answer "yes" for negative HIV tests or negative pregnancy tests.)	☐ Yes ☐ No	☐ Yes ☐ No
b. been advised to have a medical consultation, diagnostic test or surgery that has not been done?	☐ Yes ☐ No	☐ Yes ☐ No
7. To the best of your knowledge and belief, are you taking any prescription medications not disclosed in response to previous questions?	☐ Yes ☐ No	☐ Yes ☐ No

Question Number	Insured Name	Details (name of condition, dates, how treated, current status)	Name and Address of Doctor or Medical Facility

G. PERMIT TO OBTAIN AND DISCLOSE CERTAIN DATA

1. The Company, its reinsurers, consumer reporting agencies, and other parties acting on The Company's behalf may get data about my health, medical history, prescription medication history and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, finances, credit history, insurance history, driving record, and any criminal record. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for The Company to determine its obligations under the policy issued in connection with this application.
2. Any doctor, practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, the Medical Information Bureau, Inc. (MIB, Inc.), viatical settlement company, employer, consumer reporting agency, creditor, government agency, affiliated or unaffiliated insurance or reinsurance company or any other person or entity which has such data about me may give such data to The Company and its reinsurers when this Permit or a copy of it is shown. All sources but the MIB, Inc., may give such data to agents or agencies acting on behalf of The Company. The information as provided herein pursuant to the authorization will not be re-disclosed unless authorized by me or otherwise required by law. Covered Entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Permit is signed. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.
3. Any request by The Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable statutes governing patient access to medical records.
4. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs is to be included.
5. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.
6. This Permit is good for 24 months after it is signed. **I understand that, if applicable, my electronic signature on this form operates as my original signature.**
7. The Company may obtain an investigative consumer report ("inspection report") on me. ☐ I want to be interviewed if such a report is obtained.
8. I have read this Permit and know I may request a copy of it. I may revoke at any time my authorization for the release of nonpublic personal health information by writing to The Company. I also have received the Disclosures and Notices.

H. DECLARATIONS

1. I (each undersigned) have read the application and declare that all answers on this application are true and complete to the best of my knowledge and belief.
2. The Company may add to or correct the application for reinstatement on an addendum page. Any changes are agreed to if I (we) accept the policy. Any change in plan of insurance, amount, age at issue, class or benefits shall require the written consent of the owner and the primary insured.
3. Insurance will not start again until this application for reinstatement has been approved and all premiums required for reinstatement have been paid.
4. I have read and understand this application, including the Disclosures and Notices, which I acknowledge receiving.
5. Only an officer of The Company may change this application or waive a right or requirement. The agent does not have The Company's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt.

ALL QUESTIONS WERE ASKED OF ME AND, IF APPLICABLE, THE ADDITIONAL/JOINT INSURED AND PARENTS OF ANY CHILDREN LISTED ON THIS APPLICATION. I (WE) HAVE READ ALL INFORMATION BEFORE SIGNING.

I declare that the answers and statements completed on this application are full and correct to the best of my knowledge and belief. I understand and agree that the statements above, along with the application, will be the basis for any insurance issued.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Substitute Form W-9 - Under penalties of perjury, I certify that:

1. **The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and**
3. **I am a U.S. citizen or other U.S. person; and**
4. **The FATCA code entered on this form (if any) indicating that the payee is exempt from FATCA reporting is correct.**

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

SIGN HERE

Signature of Owner, if other than Primary Insured (and title, if applicable, such as "Trustee" or "President")	DATE (MM/DD/YYYY)	SSN/TIN (Trust Tax ID if Owner) ☐☐☐☐☐☐☐☐☐
Signature of Primary Insured (signature of juvenile if age 15 or older)	DATE (MM/DD/YYYY)	SSN/TIN ☐☐☐☐☐☐☐☐☐
Signature of Additional/Joint Insured	DATE (MM/DD/YYYY)	SSN/TIN
Signature of Parent/Legal Guardian (if any Insured is under Age 18)		DATE (MM/DD/YYYY)
Signature of Agent	Agent Printed Name	FL License Number ☐☐☐☐☐

L. DISCLOSURES AND NOTICES - Please leave with Primary Insured and Owner

IMPORTANT INFORMATION REGARDING MEDICAL EXAMS

As part of the underwriting process we may ask for medical tests or exams to be completed at our expense. Common tests may include a paramedical exam, which will consist of questions about your medical history and measurements of your body including, but not limited to height, weight, blood pressure, and pulse. Blood and urine specimens are also generally collected. Undressing is not required for any of these tests. In some instances, an EKG (Electrocardiogram) may be required. An EKG is a recording of the electrical impulses in the heart. You will be asked to lay down with your shirt unbuttoned so the EKG leads can be placed on your chest.

If you have any questions about the specific tests that will be required of you, please feel free to contact your agent.

NOTICE REGARDING THE MIB

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INSURANCE INFORMATION PRACTICES

We will rely primarily on the information you give us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Notice Under the Federal Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have the right to be told about and to see and copy items of personal information about you that appear in our files, including information contained in the investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to Underwriting Department, Surety Life Insurance Company, P.O. Box 660191, Dallas, TX 75266-0191.

NOTICE UNDER THE FEDERAL FAIR CREDIT REPORTING ACT

In compliance with the Federal Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. This would be by personal interviews with neighbors, friends, associates, or other persons. This will concern the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You may obtain additional information concerning the nature and scope of this investigation and a written summary of your rights under the Federal Fair Credit Reporting Act by contacting our Home Office. Our address is Surety Life Insurance Company, P.O. Box 660191, Dallas, TX 75266-0191. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

NON-SUFFICIENT FUNDS (NSF) FEE

This notice is to inform you of a fee The Company may charge in the event that a life insurance policy premium payment and/or loan payment is not honored by your financial institution due to NSF. In the event there is a NSF transaction, we may charge a NSF fee up to $25.00 (fee varies by state). If your policy is on bank draft, we may draft your account for the NSF fee. If your policy is on direct bill, we may send you a paper bill for the NSF fee.

The NSF fee is separate from your policy premium payments. All policy premium payments must be made within the required time period to keep your policy in force.

For Applicants in Florida: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.