APPLICATION FOR REINSTATEMENT TO SECURITY LIFE OF DENVER INSURANCE COMPANY

Security Life Center • 1290 Broadway • Denver, Colorado • 80203-5699 • (303) 860-1290

The following answers and statements apply to **all persons** described in Policy or Certificate No. ____________________

Before the insurance will be reinstated, Security Life must determine if the persons who were covered by the policy are still insurable. Also, all past due amounts under the policy must be paid. No insurance will be in force until these requirements are met.

1. ☐ Reinstate

2. Has any proposed insured for insurance (Include owner if owner's waiver of premium benefits applied for):	YES	NO
a. ever smoked cigarettes? (If yes, for how long? amount per day?)	☐	☐
b. stopped smoking cigarettes? (If yes, date last smoked?)	☐	☐
c. flown within the last 2 years, or have plans to fly, other than as a passenger on a regularly scheduled airline? (If yes, complete Aviation Supplement)	☐	☐
d. any plans to travel or reside outside of the USA or Canada?	☐	☐
e. in the last 2 years: had a driver's license denied, revoked or suspended; had 3 or more moving violations; been convicted of an alcohol-related driving offense; been involved in 2 or more auto accidents?	☐	☐
f. participated in the last 2 years (or intend to) in hazardous sports such as vehicle racing, sky or skin diving, etc.?	☐	☐
g. been convicted of a felony in the last 5 years?	☐	☐
h. any current participation in a regular physical exercise program? (If yes, what activity? For how long? How often?)	☐	☐
i. ever had insurance (or reinstatement) postponed, limited, rated, cancelled, refused, or declined?	☐	☐
j. have any other insurance applications pending or intended?	☐	☐
k. any reason to believe present health is not good?	☐	☐
l. ever had, or now have, any type of heart disease or high blood pressure?	☐	☐
m. ever had, or now have, any type of cancer, leukemia, or malignant tumor?	☐	☐

Details of "Yes" answers:

3. Has any Proposed Insured ever been treated for, have any sign or symptom of, or been told that the person has:	Yes	No
a. high blood pressure?	☐	☐
b. pain, pressure or discomfort in the chest, palpitation, heart murmur, rheumatic fever or other heart disorder?	☐	☐
c. anemia, spleen, varicose veins or other disorder of the blood, or blood vessels?	☐	☐
d. asthma, pleurisy, tuberculosis or other disorder of the lungs or respiratory system?	☐	☐
e. epilepsy, convulsions, dizziness, fainting spells, paralysis, mental illness, nervous breakdown or other disorder of brain or nervous system?	☐	☐
f. hernia, ulcer or other disorder of the stomach, gallbladder, liver, pancreas, intestines or rectum?	☐	☐
g. diabetes, thyroid or other glandular disorder?	☐	☐
h. arthritis, back trouble, gout or other disorder of the skin, bones or joints?	☐	☐
i. a polyp, tumor or cancer?	☐	☐
j. sugar, albumin or blood in the urine?	☐	☐
k. cystitis, nephritis, kidney stones, urethritis or other disorder of the urinary tract?	☐	☐
l. mastitis, prostatitis, veneral disease or other disorder of the genital or reproductive organs?	☐	☐
m. any disorder of the eyes or ears, nose or throat	☐	☐
n. disease, illness, injury or impairment within the last 5 years not mentioned above?	☐	☐
4. Within the last 5 years has any Proposed Insured ever had or been advised to have:		
a. a surgical operation?	☐	☐
b. an x-ray, electrocardiogram or other test?	☐	☐
c. treatment, consultation or observation in a physician's office, hospital, clinic or sanitarium?	☐	☐
5. Has any Proposed Insured had a physical exam within the last 5 years? (Give names of physicians, dates and reasons for all exams)	☐	☐
6. Does any Proposed Insured:		
a. have any deformity or amputation?	☐	☐
b. now take any kind of medication?	☐	☐
7. Has any Proposed Insured ever:		
a. used alcohol or marijuana? (If so, how often? How much?)	☐	☐
b. used narcotics, hallucinatory or mind altering substances not prescribed by a physician?	☐	☐
c. received advice about or been treated for use of alcohol or drugs?	☐	☐
8. Has any parent, brother or sister of such person ever had cancer, diabetes, high blood pressure, heart or kidney disease, nervous or mental disorder, tuberculosis or hereditary disorder?	☐	☐

PARTICULARS REGARDING EACH "YES" ANSWER TO QUESTIONS 3 THROUGH 8 (please print)

Question No.	*Name of Person*	*Name of Disease Symptom, Injury, Etc.*	*Date of Onset*	*Duration*	*Number of Attacks*	*Names and Addresses of Physicians & Hospitals*

9. Names and addresses of personal physicians:

Proposed Insured	*Physician*	*Address*

RELIANCE: All statements and answers in this application including any supplements and amendments are true and complete to the best of my knowledge and belief. The statements and answers in the application for the original policy were true and complete on the date of that application. Both the original application and this application will be relied upon and form the basis for reinstating any insurance. No information will be considered as having been given to Security Life unless it is stated in these applications.

CONDITIONS PRECEDENT: No reinstated insurance shall be in force until: (a) any required payment for the request is paid in full, and (b) the request is approved by Security Life while the facts and health condition of those to be insured remain the same as represented in this application. Even if Security Life deposits payment made with this application, it may decline the request. Security Life may require additional evidence of insurability before approving this request.

INCONTESTABILITY: If the policy is reinstated, the policy date for the purpose of the incontestability shall be the date of this application.

LIMITED AUTHORITY OF AGENT: No agent or any other person, except an officer of Security Life, can make or change any insurance contract or bind Security Life by making promises regarding any contract. Any change must be in writing and signed by an officer of Security Life.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Security Life of Denver Insurance Company ("Security Life") may obtain information about me or my minor children from: any physician; medical practitioner; hospital, clinic or other medical facility; employer; other insurance companies or institutions; consumer reporting agency; or Medical Information Bureau, Inc. ("MIB, Inc."). The purpose is to evaluate my application for insurance or benefits. Security Life may obtain an investigative consumer report and any records or other information available as to diagnosis, treatment and prognosis of any physical or mental condition.

Security Life may obtain any drug, physical and mental health, and alcohol-related information which may be protected by federal or state laws and regulations. As it pertains to alcohol and drug information covered by federal regulation, this may be revoked at any time by written notice to Security Life. But, any action taken before my written revocation is received by Security Life will not be affected.

Security Life may make a brief report about me or my children to MIB, Inc. Security Life may disclose information to: its reinsurers; those who perform services for Security Life on any application for insurance or benefits; or those companies to which I have applied or may apply for life or health insurance, or benefits. Disclosure may be made when required or permitted by law.

This is valid for two and one-half years from the date below. An original or copy may be used by Security Life or its authorized representative to obtain information. I have read and received a copy of this authorization, I also have a copy of the Notice of Information Procedures. It includes the MIB, Inc. and Fair Credit Reporting Notices.

The amount enclosed is $__________. This payment will be refunded if the policy is not reinstated.

Signature of:
Proposed Insured ____________________ Date ________________, 19___
(If below age 15, signature of parent or guardian required)

Spouse (if applicable) ____________________ ____________________

Applicant-Owner ____________________ ____________________

If a firm or corp. is to be owner, print its name. Also have an officer sign as applicant-owner.

Agent/Witness ____________________

Address for Notices ____________________

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INSTRUCTIONS: **Detach and keep Applicant's Information (Conditional Receipt).**
Return Reinstatement Application to Security Life of Denver Insurance Company