NORTH CAROLINA MUTUAL
LIFE INSURANCE COMPANY

Application for Reinstatement

Policy Number _____ **Name of Primary Insured** _____

I (we) hereby make application to North Carolina Mutual Life Insurance Company for reinstatement of this policy which has lapsed for non-payment of premium.

The following questions are to be answered with respect to all persons named as insureds under this policy:

	YES	NO
1. Are you currently confined to a penal institution, a hospital or a resident in a nursing home or have you ever been diagnosed as having a terminal illness or Alzheimer's disease?	☐	☐
2. Within the past three years have you had any ailment, sickness, accident or been examined or treated by a physician or medical practitioner?	☐	☐
3. Within the past three years have you received or been advised to receive treatment for alcohol or drug use or abuse or had your drivers license revoked or suspended?	☐	☐
4. Have you ever received treatment for or been diagnosed as having an immune deficiency disorder, HIV infection, AIDS or AIDS Related Complex? (ARC is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause.)	☐	☐
5. Have you, within the past three years, been declined for life insurance or been offered a policy other than the one you applied for?	☐	☐

If you answered "Yes" to any question, please explain.

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Declaration and Authorization:

I hereby declare that the statements recorded above are true and complete to the best of my knowledge and belief. I understand that no agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the proposed insured.

I authorize any licensed physician, or medical practitioner who has any record or knowledge of the proposed insured's medical history to give any such information to North Carolina Mutual Life Insurance Company. A photocopy or facsimile of this authorization shall be as valid as the original.

_____ _____ _____

Date Application State Applicant Signature

_____

Applicant Address City, State, Zip