Application for Reinstatement

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

Policy Number	Proposed Insured	Spouse (If spouse coverage)
Premium Collected	Mode/Method of Payment	**Home Office Use Only**

I hereby apply for Reinstatement.

As an inducement to the Company to approve this application, I agree that:

a. The statements and answers in this application are true and complete.
b. No insurance will be in force until this application is approved:
   1. during the lifetime and sound health of the proposed insured; and
   2. also during the lifetime and sound health of the spouse and the children, if they are covered under the policy or any rider being reinstated.
c. Approval of this application will be void if at any time within two years from the approval date any of the statements or answers are found to be untrue.
d. If approved:
   1. this application, along with the original application, will become part of the policy described above; and
   2. a copy will be returned to the policyowner to attach to the policy.

If Spouse coverage, complete 1a and 2a.

1. Proposed Insured's Occupation	2. Exact Height - Weight Ft. In. Lbs.	Has weight changed more than 10 lbs. in past year? ☐ Yes ☐ No If yes, amount of increase _____ decrease _____	Date of Birth
1. a. Spouse's Occupation	2. a. Exact Height - Weight Ft. In. Lbs.	Has weight changed more than 10 lbs. in past year? ☐ Yes ☐ No If yes, amount of increase _____ decrease _____	Date of Birth

The representations made below apply to **EACH PERSON** who would be insured under the policy, including any riders, if reinstated. These individuals include: the insured; any person other than the insured on whose death the premiums would be waived; the insured's spouse or children; and any other individual covered by the stated policy.

3. Since the date of the original application has any proposed insured:	
a. Had any consultation or treatment by a member of the medical profession, physician or practitioner, examination in a clinic, hospital, dispensary, or sanitarium; any surgical operation, x-ray, electrocardiogram, or other tests, or been told there is a need for them?	❑ Yes ❑ No
b. Had or been told they have any disease, illness, impairment or injury, either physical or mental, by a member of the medical profession?	❑ Yes ❑ No
c. Ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune disorder?	❑ Yes ❑ No
d. Been exempted or discharged as unfit from military service; applied for any kind of disability compensation; or had an application for life or health insurance: declined; postponed; limited; or issued other than as applied for?	❑ Yes ❑ No
e. Engaged in or contemplate engaging in scuba or sky diving, racing, or other hazardous sports; or made or contemplate making flights as a pilot or student pilot?	❑ Yes ❑ No
f. Had a driver's license revoked or suspended or been convicted of a felony; sought or received advice, counseling or treatment by a member of the medical profession for the abuse of alcohol or drugs; used (other than as prescribed by a member of the medical profession) narcotics, cocaine, heroin, amphetamines, barbiturates, hallucinogens, or marijuana; used alcohol to the point of intoxication on a regular basis?	❑ Yes ❑ No
g. Used any nicotine products in the past 12 months?	❑ Yes ❑ No

Details of "Yes" answers to any questions:

WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ this _____ , _____
Month Day Year

X _____ X _____
Signature of Agent Signature of Proposed Insured

X _____ X _____
Signature of Witness, if Agent not Present Signature of Spouse

_____ X _____
Current Address of Payor Signature of Owner – If Other Than Proposed Insured

_____ X _____
City/State/Zip of Payor Signature of Owner – If Other Than Proposed Insured

_____
Social Security Number of Insured/Owner

AUTHORIZATION

I hereby authorize any: licensed physician; medical practitioner; hospital; clinic or other medical or medically related facility; insurance company; MIB, Inc.; or other organization, institution or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of: physical and/or emotional illness; communicable diseases; alcohol or drug abuse treatment; and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is reinstated.

_____ X _____
Date Signature of Proposed Insured
(Required on proposed insureds age 15 and up)

AUTHORIZATION

I hereby authorize any: licensed physician; medical practitioner; hospital; clinic or other medical or medically related facility; insurance company; MIB, Inc.; or other organization, institution or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of: physical and/or emotional illness; communicable diseases; alcohol or drug abuse treatment; and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is reinstated.

_____ X _____
Date Signature of Owner

AUTHORIZATION

I hereby authorize any: licensed physician; medical practitioner; hospital; clinic or other medical or medically related facility; insurance company; MIB, Inc.; or other organization, institution or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of: physical and/or emotional illness; communicable diseases; alcohol or drug abuse treatment; and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is reinstated.

_____ X _____
Date Signature of Spouse

IMPORTANT: All past due premiums must be paid current before an application for reinstatement will be reviewed. If a billing option is not specified and your application is approved, then the policy will be placed on direct monthly billing.

DIRECT PAYMENT OPTIONS

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

MONTHLY BANK DRAFT

TO BEGIN MONTHLY BANK DRAFT, THE AUTHORIZATION BELOW MUST BE COMPLETED AND ACCOMPANIED BY A CHECK MARKED "VOID."

THE MONTHLY DRAFT DATE WILL BE THE SAME AS THE POLICY DATE UNLESS INDICATED.

Bank Name _____ Bank Account Number _____ Bank Routing Number _____

Bank Address: City/State/Zip _____

Requested Draft Date (1st – 30th) _____ ☐ Checking ☐ Savings

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY
Indianapolis, Indiana

As a convenience to me, I hereby request and authorize you to pay and charge to my account, debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice, I agree that you shall be fully protected in honoring any such debit entry.

I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ X _____

Date Signature of Premium Payor (name must appear on void check)

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life 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 a 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 it may have in your file. If you question the accuracy of 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, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life 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.

I declare that I have read and understand the above notice.

Dated at _____

this _____ (Month) _____ (Day), _____ (Year)

X _____
Signature of Agent

X _____
Signature of Proposed Insured
(Required on proposed insureds age 15 and up.)

X _____
Signature of Spouse

X _____
Signature of Owner – If Other than Proposed Insured

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

Authorization for Release of Medical Information

United Home Life Insurance Company
P.O. Box 7192, Indianapolis IN 46207-7192

This authorization complies with the HIPAA Privacy Rule.

_____ _____ / _____ / _____

Name of proposed insured/patient **(please type or print)** Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

_____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Authorization for Release of Medical Information

United Home Life Insurance Company
P.O. Box 7192, Indianapolis IN 46207-7192

This authorization complies with the HIPAA Privacy Rule.

_____ _____ / _____ / _____

Name of proposed insured/patient **(please type or print)** Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

_____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient