

APPLICATION FOR REINSTATEMENT ACCIDENT ONLY

*PAYMENT MUST ACCOMPANY THIS FORM. PLEASE DO NOT RETURN VIA FAX. WE MUST HAVE THE ORIGINAL .
PLEASE RETURN VIA THE MAIL.*

POLICY # PARTICIPANT # PAID-TO-DATE AMOUNT DUE

INSURED'S NAME _____ SSN _____

STREET ADDRESS _____ DATE OF BIRTH _____ AGE _____

CITY/STATE/ZIP _____ HEIGHT _____ WEIGHT _____

HOME PHONE _____ OCCUPATION _____

WORK PHONE _____ EXACT JOB DUTIES _____

BENEFICIARY _____ SSN _____ RELATIONSHIP _____

PLEASE FURNISH DETAILS TO ALL "YES" ANSWERS AND YOUR PERSONAL PHYSICIAN'S NAME AND ADDRESS EVEN IF YOU ANSWER "NO" TO ALL QUESTIONS.

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you been hospitalized for more than 5 days or been absent from work due to an accident or sickness for more than 5 consecutive work days during the past 12 months? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you been treated for injuries suffered on or off the job withing the past 12 months? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Are you currently under the care of a physician? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you have residual problems as a result of injuries that occurred during the past 12 months? |

QUESTION #	DETAILS OF "YES" ANSWERS. PLEASE INCLUDE DATES, DURATION, ATTENDING PHYSICIAN'S OR HOSPITAL'S NAME, ADDRESS OR PHONE NUMBER	PROVIDE PERSONAL PHYSICIAN'S NAME AND ADDRESS

To the best of my knowledge and belief, all of my statements and answers are true and complete. I agree that reinstatement of the policy as granted by Colorado Bankers Life Insurance Company upon the application, shall be contestable for fraud or misrepresentation of any material facts stated herein or in connection herewith for two years from the date of reinstatement and that this reinstatement application shall become a part of the contract of insurance. I understand that my coverage is not to be considered reinstated until this application has been approved by the Company during my lifetime and past due premium has been paid. Payment of the past due premium is not binding upon the Company until this application is approved.

I hereby authorize any physician, medical practioner, hospital, clinic, Heath Maintenance Organization, including Mayo, Kaiser Foundation, Veterans Administration, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institute, or person that has any records or knowledge of me or my family, or our health, medical history or physical condition, to give Colorado Bankers Life Insurance Company or its reinsurers any such information including psychiatric histories and testify as to such information.

This authorization is valid for thirty (30) months after the date it was signed. A photo static copy of this authorization will be as valid as the original.

DATE _____ SIGNATURE OF INSURED _____