

APPLICATION FOR REINSTATEMENT
TIMBER RIDGE CRITICAL ILLNESS

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 _____

CITY/STATE/ZIP _____ HEIGHT _____ WEIGHT _____

HOME PHONE _____ OCCUPATION _____

WORK PHONE _____

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

1. Have you or any family member to be covered ever been told you had or been treated for any of the following (check all that apply and give details on the next page):

- a. Cancer, tumor, ulcer, neurological disorder or related disease, or disease of the breast or reproductive organs?
- b. Heart attack, angina pectoris, chest pain, high blood pressure or any other disease of the heart or blood vessels?
- c. Disease of the kidney, urinary bladder, stomach intestines, liver, gall bladder, lungs or respiratory system, nervous or mental disorder?
- d. Diabetes, chronic hepatitis, leukemia, internal organ transplant, cirrhosis of the liver, or paralysis?
- 2. Have you ever been diagnosed or treated for or been told you will require treatment for a disorder of the Immune System including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other AIDS-related condition or had a positive test for the AIDS virus (HIV)?
- 3. Have you ever had or been treated for alcohol or drug abuse or addiction? (If yes, give full details on the next page)
- 4. Have you been hospitalized, consulted a physician, or received treatment for any illness or injury in the past 5 years, other than as stated above?
- 5. Have you smoked cigarettes or used tobacco product(s) in the past 12 months?
- 6. Have you missed more than 5 consecutive days of work due to accident or sickness in the past 12 months?
- 7. Have you ever been declined or rated-up for life or health insurance?
- 8. Within the past 2 years have you been advised to have any diagnostic tests, hospitalization, surgical procedure or treatment that has not been done?
- 9. Do you currently have any growth, cyst or lump or any new pigmented area of skin that has not been evaluated by a physician?
- 10. Within the past 5 years have you had any symptoms for which future medical assessment is planned, contemplated, or for which you have not yet consulted your physician?
- 11. Are you currently taking, or been advised to take, prescription drugs? Indicate drugs and prescribing physician on the next page.

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 practitioner, hospital, clinic, Health 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 _____