Colorado Bankers Life
Insurance Company®

A Dearborn National™ BRAND COMPANY

5990 Greenwood Plaza Boulevard
Greenwood Village, Colorado 80111
303.220.8500 ▲ 800.367.7814
www.dearbornnational.com

APPLICATION FOR REINSTATEMENT

MODIFIED WHOLE LIFE/TEN YEAR TERM

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	
		1. During the past ten years, have you or any person to be covered by the policy applied for, been told you had or had been treated for:
☐	☐	a. Cancer, Heart Disease or High Blood Pressure?
☐	☐	b. Diabetes or Disease of the Liver or Kidneys?
☐	☐	c. Been hospitalized for Nervous or Mental Disorder?
☐	☐	d. Alcoholism, Narcotic Addiction, Drug Habituation?
☐	☐	e. Immune Deficiency or any other Blood Disorder?
☐	☐	2. Have you had medical or surgical advice or treatment or been confined in a hospital during the past 5 years other than stated above?

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 ____________________

Dearborn National™

COLORADO BANKERS LIFE
Insurance Company

Prescription History Authorization

I, the undersigned Designated Person, or his or her authorized representative, both referred to as (“I”) in this document

Designated Person’s Name:____
First Middle Last

Other Names Used:____

Date of Birth:_______________ Social Security Number:____

hereby authorizes any and all medical practitioners, physicians, pharmacists, pharmacy benefits managers, health care clearing houses, hospital, clinics, nurses, or records custodians to release any and all records and information within their possession, custody or control, regarding my/the Designated Person’s diagnosis, testing, treatment and prognosis, including any information and records regarding my/the Designated Person’s physical or mental condition, and including, but not limited to, records and information concerning my/the Designated Person’s: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG’s as follows:

Such information and records may be released to and exchanged between the insurance company and the Other Party listed below, as well as the Insurer’s and the Other Party’s agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

Insurer	**Other Party**
Colorado Bankers Life Insurance Company	EMSI
5990 Greenwood Plaza Blvd	P.O. Box 2505
Suite 325	Waco, Texas 76702-2505
Greenwood Village, Colorado 80111	

The purpose of this disclosure is to evaluate my/the Designated Person’s application for insurance or claim benefits.

I understand that when my/the Designated Person’s medical records are disclosed pursuant to this Authorization, I/the Designated Person‘s medical records and the information contained in those records may become subject to further disclosure by the insurance company. For example, the insurance company may be required to provide such information to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. This Authorization will remain in effect a maximum of six (6) months from the date of signature below. I understand I may revoke this Authorization as to the Insurer and/or the Other Party at any time, by requesting such action of the Insurer and/or the Other Party to whom such revocation is to apply, in writing at their address stated above, unless action has already been taken in reliance upon this Authorization, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this authorization to release my/the Designated Person’s complete medical records, my/the Designated Person’s insurance company may not be able to process my/the Designated Person’s application for coverage, or if coverage has been issued, may not be able to make any benefit payments.

Signature of
Designated Person/guardian/
personal representative: ____ **Date:** _______________

Legal relationship to applicant: ____
(Only if signed above by guardian or personal representative)