

Policy Number _____



36 South State, Salt Lake City, Utah 84136

Telephone: (801) 933-1100 • (800) 233-7979

BENEFICIAL LIFE INSURANCE COMPANY

Application to Reinstate Insurance

I. Policy Identification

Policy Number _____ Policyowner Name _____ SSN _____

Policyowner Address _____

Primary Insured Name _____ Height _____ Weight _____

Insured Daytime Phone (_____) _____ Insured Evening Phone (_____) _____

Insured Occupation _____ Insured Employer _____

II. Underwriting Information

The representations made below apply to **EACH PERSON** who would be insured under the policy, 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 individuals covered by the stated policy.

1. Since the date of the original application or change to the application, has any insured:
 - a. Consulted or been treated by a physician or other practitioner? _____ No _____ Yes
 - b. Been referred or admitted to a hospital, sanatorium, clinic or other institution for diagnosis, observation, operation or treatment? _____ No _____ Yes
 - c. Been treated for, tested positive for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) AIDS Related Complex or other immune deficiency disorder? _____ No _____ Yes
 - d. Been rated, postponed, declined or waived for life, accident or health insurance? _____ No _____ Yes
 - e. Engaged in aviation or hazardous sports or hobbies, or expects to do so? _____ No _____ Yes
2. Does the insured or any other persons insured under the policy now have any diseases, deformities or impairments, either physical or mental? _____ No _____ Yes
3. Provide full details of all "yes" answers from above.
Attach Additional Sheets as necessary.

Insured Name	Condition	Date Occurred	Recovery Complete?	Physician Name and Address

III. Authorization

I/we, the undersigned, understand that this policy has lapsed for non-payment of premium and that reinstatement may be made only upon (1) evidence of insurability satisfactory to Beneficial Life, (2) upon payment sufficient to meet past premiums due, plus interest, and (3) payment or reinstatement of any other indebtedness to Beneficial Life, related to this policy. Additionally, two months' advance premium is due with this application for reinstatement. No statement or promise has been made to me/us in any way conflicting with or waiving these conditions or extending the time for payment of any premium. To the best of my knowledge the above answers are complete and true. I agree that the reinstatement of this policy shall be contestable at any time within two years from the reinstatement approval date. I acknowledge that this policy will not be in force until this reinstatement application has been approved, and all payments have been received in the Beneficial Life Home Office.

I hereby expressly authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau Inc., investigative consumer reporting agency, or government agency, that has any records or knowledge of me or my family concerning our health, finances, driving record, general activities, character and vocation, to give any such information to the Beneficial Life Insurance Company and its reinsurers. This authorization is valid for 2 1/2 years from the date signed. Upon request, a copy of this authorization will be provided to you, and a photographic copy shall be as valid as the original.

I recognize that I may request a copy of this authorization and acknowledge receipt of an Application to Reinstate Insurance Disclosure form.

Signature of Owner

Date

Signature of Insured (if other than Owner)

Date

BENEFICIAL LIFE INSURANCE COMPANY

Application to Reinstate Insurance Disclosures

To be delivered to the insured and the policyowner.

Notice of Disclosure of Information

Information regarding your insurability will be kept confidential except that Beneficial Life Insurance Company or its reinsurers may make a brief report to the Medical Information Bureau. Upon request by another insurance company, to which you have applied for life or health insurance or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files. Beneficial Life Insurance Company or its reinsurers may also release information in its file to its reinsurers and to other life insurance companies to which you may apply for life or health insurance or to which a claim is submitted.

Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have under your name. Medical information will only be disclosed to your attending physician. If you question the accuracy of information in the Bureau's file you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, MA 02112, telephone (617) 426-3660.

Notice to Proposed Insured

The law requires you to be advised that in connection with your application for reinstatement of insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics, and mode of living.

You have a right to access and correct the information we collect about you, except that information which relates to a claim, civil, or criminal proceeding. You are entitled to be interviewed in connection with any investigative consumer report, and receive a copy of any such report. If you wish to have a more detailed explanation of our information practices, please make such a request, in writing, to the Beneficial Life Insurance Company, Underwriting Department, 36 South State Street, Salt Lake City, Utah 84136



BENEFICIAL LIFE INSURANCE COMPANY

Notice and Consent Form for AIDS Virus (HIV) Antibody/Antigen Testing

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form you agree that these tests may be performed and that underwriting decisions (i.e., decision to accept or reject your application) will be based on the test results.

You may have ten (10) days to decide whether you wish to sign this form. You may refuse to be tested. However, such refusal may be used by the insurer as a reason to deny coverage. Please see below for additional counseling information.

Information on HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. *HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread through kissing.*

Persons most at risk of contracting HIV are men who have sex with other men, intravenous ("IV") drug users, prostitutes (male and female), persons who have had many sexual partners since 1977, persons who received transfusions of blood or blood products prior to March 1985, the sexual partners of persons in any of these groups; and infants born to infected mothers.

Pre-Test Counseling Considerations

Many public health organizations have recommended that before taking an HIV antibody/antigen test, a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. Free, confidential counseling is available in most Arizona communities. Information regarding the availability of counseling is available in the Phoenix area from the Arizona AID Information Line, (602) 234-2752 and outside the Phoenix area from the Arizona Department of Health Services, (800) 334-1540.

Disclosure of Test Results

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not be otherwise disclosed without your written consent except as required or allowed by law. *Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. Section 20-448-01.*

Meaning of Positive Test Results

The most commonly used test for HIV is designed to detect the presence of antibodies to the virus. Antibodies are made by the body's immune system to fight infection. While positive HIV antibody test results do not mean that you have AIDS, they do indicate that you have been infected with HIV, the virus that causes AIDS. About 50% of infected individuals have developed AIDS within 10 years after being infected with the virus.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

Consent

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have a right to request and receive a copy of this form. A photocopy of this form will be as valid as the original. This consent is valid for a period not to exceed 180 days.

Proposed Insured Signature (Parent/Guardian if a minor)

Date

Optional Release of Information to Personal Physician

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

Physician Name and Address

Proposed Insured Signature (Parent/Guardian if a minor)

Date

**Authorization for Release of Health-Related Information
to Beneficial Life Insurance Company
This authorization complies with the HIPAA Privacy Rule**

Name of proposed insured/patient (please print)

____/____/____
Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, practitioner, consumer reporting agency, government agency, group policyholder, employer, benefit plan administrator, insurance company, reinsurer, insurance support organization, Veteran's Administration entity, medical facility, representative of the Medical Information Bureau, Inc., pharmacy-benefit manager, health care provider, or other person or entity that has provided payment, treatment, record-keeping, diagnosis, information or services to me or on my behalf within the past 10 years, ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the Beneficial Life Insurance Company ("Beneficial Life") and its agents, employees, reinsurers, and representatives. 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, agent, officer or employee affiliated with My Providers to release and disclose my entire medical record without restriction. If an investigative consumer report is required in connection with my application, I hereby request a personal interview by checking here ____ .

This protected health information is to be disclosed under this Authorization so that Beneficial Life 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 Beneficial Life. Any information obtained will be used and shared by Beneficial Life only as necessary to perform business or legal services in connection with my application, claim, or policy.

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 sending a written request for revocation to Beneficial Life at Beneficial Life Insurance Company, Privacy Official, 36 South State Street, Salt Lake City, Utah 84136. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Beneficial Life 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 redisclosed 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, Beneficial Life may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization and have the right to request another copy at any time. I acknowledge receipt of the Notice of Disclosure of information and Notice to Proposed Insured.

I agree that an accurate replica of this authorization shall be considered as valid and effective as the original. Where relevant, this authorization shall apply to my minor dependants if signed to obtain services from Beneficial Life on their behalf, and the word "I" shall be read throughout this authorization to include both me and my minor dependants.

Signature of Proposed Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

**Authorization for Release of Health-Related Information
to Beneficial Life Insurance Company
This authorization complies with the HIPAA Privacy Rule**

Notice to Proposed Insured

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You have a right to access and correct the information we collect about you, except that information which relates to a claim, civil, or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please make such a request, in writing, to the Beneficial Life Insurance Company, Underwriting Department, 36 South State Street, Salt Lake City, Utah 84136.

Notice of Disclosure of Information

Information regarding your insurability will be treated as confidential except that Beneficial Life Insurance Company or its reinsurers may make a brief report to the Medical Information Bureau. Upon request by another insurance company, to which you have applied for life or health insurance, or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files. Beneficial Life Insurance Company or its reinsurers may also release information in its file to its reinsurers and to other life insurance companies to which you may apply for life or health insurance or to which a claim is submitted.

Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have under your name. Medical information will only be disclosed to your attending physician. If you question the accuracy of information in the Bureau's file you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, MA 02112, telephone (617) 426-3660.

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BENEFICIAL LIFE INSURANCE COMPANY

Statement of Intent for a Modified Endowment Contract

Please select either Option I or Option II, signifying your intent for the policy listed.

Policy Identification

Policyowner Name _____ Policyowner SSN _____

Insured Name _____ Policy Number (if issued) _____

Option I. Authorization for a Modified Endowment Contract

I, the undersigned, have been informed that the above listed life insurance policy purchased or intended for purchase from Beneficial Life Insurance Company has or may become a Modified Endowment Contract as defined by Section 7702A(a)(1) of the Internal Revenue Code.

I understand the following applies to a Modified Endowment Contract:

- a. A Modified Endowment Contract is a life insurance policy;
- b. As life insurance, the death benefit is payable income tax free to the named beneficiary;
- c. As life insurance, cash values accumulate on a tax deferred basis until withdrawn or borrowed;
- d. Withdrawals and loans are treated as reportable income, up to the amount of gain in the policy; and
- e. A 10% penalty tax may be imposed upon any distribution, if made prior to the policyowners age of 59 ½ .

I understand that Beneficial Life does not provide tax advice. I have been advised that a professional tax advisor should be contacted regarding questions on the impact of a Modified Endowment Contract on my personal tax situation.

It is my intent that the policy remain/become a Modified Endowment Contract.

Policyowner Signature

Date

Spouse Signature

Date

Option II. Request to Prevent a Modified Endowment Contract

I, the undersigned, understand that the total premiums paid to date for the above life insurance policy have caused or may cause the policy to become a Modified Endowment Contract. It is my intent for the policy **not** to become a Modified Endowment Contract. I understand that the Internal Revenue Service has established timeframes during which this change may be made. I direct Beneficial Life to make the policy a non-Modified Endowment Contract, and either:

_____ Apply the excess premium to an annuity. *I understand that an active annuity policy or an application to create a policy is required. Minimum amounts also apply.*

_____ Refund the excess premium and applicable interest to me.

Policyowner Signature

Date

Spouse Signature

Date

Recorded by _____ Date _____