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. Have you ever tested positive for HIV antibodies as part of a medical examination or as part of a test for obtaining insurance? ____ 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 or other insurance support organizations, that has any records or knowledge of me/us or of my/our health to give such information to the Beneficial Life Insurance Company and its reinsurers. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for two and one half years from the date listed below.

I acknowledge receipt of an Application to Reinstate Insurance Disclosure form.

____ ______________

Signature of Owner Date

____ ______________

Signature of Insured *(if other than Owner)* Date

Policy Number ______________________

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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 be disclosed to you or a medical professional at your direction. 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. 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

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BENEFICIAL LIFE INSURANCE COMPANY

Notice And Consent For AIDS-Related Blood Testing

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that the underwriting decisions will be based on the test result. The costs of all HIV antibody testing will be covered by the insurer. An enzyme-linked immunosorbent assay serologic (ELISA) test, which has been licensed by the federal Food and Drug Administration to detect antibodies to the HIV virus, will be performed. If this test result is positive, a second ELISA will test will performed. If the second test result is positive, a third ELISA test will be performed. If the third ELISA test result is positive, a confirmatory Western Blot Assay test will be performed, which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the HIV virus.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your own expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city may provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Result

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. If you have had a positive ELISA test result or a positive Western Blot Assay or both, your test results may be released to an insurance support organization or another insurer using a nonspecific test result code that does not indicate that you were subject to testing related to the human immunodeficiency virus.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will be notified. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you may choose to have your test results forwarded to a private physician or your county health department. Please designate the party or parties to receive notification of your test results (you may designate more than one).

___Applicant
___Private Physician ______________________________
Name

____
Address

___County Health Department ______________________________
Name

____
Address

Consent

I have read and I understand this Notice and consent for AIDS-related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of blood, and the disclosure of the test results as described above. I have read the information on this form about what a positive test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This consent authorization is limited to six months from the date of signature.

______________________________ ______________________________
Signature of Proposed Insured or Parent/Guardian Date Signed

Name of Proposed Insured: ______________________________
Address: ______________________________
____

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BENEFICIAL LIFE INSURANCE COMPANY

HIV Antibody Test
Information for Insurance Applicant

AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs, and others having sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 – 50% chance of developing AIDS over the next 10 years.

The HIV Antibody Test

Before consenting to testing, please read the following important information:

1. **Purpose** – An enzyme-linked immunosorbent assay serologic (ELISA) test, which has been licensed by the federal Food and Drug Administration to detect antibodies to the HIV virus, will be performed. It this test result is positive, a second ELISA test will be performed. If the second test result is positive, a third ELISA test will be performed. If the third test result is positive, a confirmatory Western Blot Assay test will be performed, which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the HIV virus. These tests are being run to determine whether you may have been infected with HIV. If you are infected you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

2. **Positive Test Results** – If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

3. **Accuracy** – An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
   a. False Positives – This test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Re-testing should be done to help confirm the validity of a positive test.
   b. False Negatives – The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at lease 4 – 12 weeks for a positive test result to develop after a person is infected.

4. **Possible Adverse Effects of Test** – A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

5. **Disclosure of Results** – A positive test result will be disclosed to you. You may choose to have information about your HIV test results communicated to you directly, or through your physician, or the county health department.

6. **Confidentiality** – Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, if you have had a positive ELISA test result or a positive Western Blot Assay or both, your test results may be provided to an insurance support organization or another insurer using a nonspecific test result code that does not indicate that you were subject to testing related to the human immunodeficiency virus. Your insurance agent will provide you with additional written information about this subject at your request.

7. **Prevention** – Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

8. **Information** – Further information about HIV testing and AIDS can be obtained by calling the California AIDS hotline in Northern California at 1-800-367-AIDS and in Southern California at 1-800-922-AIDS.

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BENEFICIAL LIFE INSURANCE COMPANY

HIV Test Counseling Resources List

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was complied from publicly available information, which is subject to change without notice to the Insurer named above. Therefore, the Insurer makes no representations or warranties that this information is accurate as of the date you receive this list. Also, the Insurer makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. If you need further information, we suggest you contact your own physician or health care provider , your county health department, or your local chapter of the American Red Cross.

AIDS HOTLINE
U.S. Public Health Service
(800) 342-AIDS

SPANISH AIDS HOTLINE
(800) 222-AIDS

CALIFORNIA HIV/AIDS HOTLINE
(800) 367-2437 or
(415) 863-2437

AIDS HOTLINE – SOUTHERN CALIFORNIA
(800) 922-AIDS

CALIFORNIA DEPT. OF HEALTH SERVICES
Statewide Services – Office of AIDS
(916) 449-5900
Sacramento

SAN JOAQUIN AIDS FOUNDATION
(209) 476-8533
Stockton

INLAND EMPIRE AIDS COORDINATION AND EDUCATION PROJECT
(714) 825-7510
Riverside

AIDS PROJECT, HEMOPHILIA COUNCIL
(714) 834-2604
Santa Ana

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

The law requires you to be advised that in connection with your application for 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. 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.

Policy Number ______________________

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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 ______________