

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 or other organization, institution or person 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



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. 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**Consent Form for HIV Test**

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

THE HIV VIRUS

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to the HIV virus are found in the blood and other bodily fluids of most people with AIDS and AIDS-Related Complex (ARC), and can be found in people who do not have AIDS or arc but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

PRE-TESTING CONSIDERATION

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

DISCLOSURE OF TEST RESULTS

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal, you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

TEST RESULTS

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with the HIV virus and infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider re-testing in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

OTHER SOURCES OF INFORMATION

For more information about AIDS you may call the Ohio AIDS Hotline at 1-800-332-2437.

CONSENT FOR HIV TESTING

I have read and I understand this HIV test informed consent form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this 90 (ninety) day period.

In the event of a positive test result:

Send the result to me at: _____
Address

I authorize Beneficial Life to send the result to another person:

Name

Address

I authorize Beneficial Life to send the result to the following physician or health care provider:

Physician's Name

Physician's Address

Authorization

Name of applicant

Signature of applicant

Date

Signature of legal guardian, if any

Date

Signature of person obtaining consent (Agent)

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

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.

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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 _____