

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 (using a FDA-licensed test) or diagnosed by a member of the medical profession 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

Wisconsin Notice And Consent For Human Immunodeficiency Testing

Request For Consent For Testing

To evaluate your insurability, Beneficial Life requests that you be tested to determine the presence of human immunodeficiency virus (HIV) antibody or antigens. By signing and dating this form, you agree that this test may be done and that underwriting decisions may be based on the test results. A licensed laboratory will perform one or more tests approved by the Wisconsin Commissioner of Insurance.

Pretesting Consideration

Many public health organizations recommend that, if you have any reason to believe you may have been exposed to HIV, you become informed about the implications of the test before being tested. You may obtain information about HIV and counseling from a private health care provide, a public health clinic, or one of the AIDS service organizations on the attached list. You may also wish to obtain an HIV test from an anonymous counseling and testing site before signing this consent form. The Insurer is prohibited from asking you whether you have been tested at an anonymous counseling and testing site and from obtaining the results of such a test. **For further information on these options, contact the Wisconsin AIDSline at 1-800-334-2437.**

Meaning of Positive Test Results

This is not a test for AIDS. It is a test for HIV and shows whether you have been infected by the virus. A positive test result may have an effect on your ability to obtain insurance. A positive test result does not mean that you have AIDS, but it does mean that you are at a seriously increased risk of developing problems with your immune system. HIV tests are very sensitive and specific. Errors are rare but they can occur. If your test result is positive, you may wish to consider further independent testing from your physician, a public health clinic, or an anonymous counseling and testing site. **HIV testing may be arranged by calling the Wisconsin AIDSline at 1-800-334-2437.**

Notification of Test Results

If your HIV test result is negative, no routine notification will be sent to you. If your HIV test result is other than normal, the Insurer will contact you and ask for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the test results.

Disclosure of Test Results

All test results will be treated confidentially. The laboratory that does the testing will report the results to the Insurer. If necessary to process your application, the Insurer may disclose your test result to another entity such as a contractor, affiliate, or reinsurer. If your HIV test is positive, the Insurer may report it to the Medical Information Bureau (MIB, Inc.), as described in the notice given to you at the time of application. If your HIV test is negative, no report about it will be made to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. These organizations may not disclose the fact that the test has been done or the result of the test except as permitted by law or authorized in writing by you.

Consent

I have read and I understand this notice and consent for HIV testing. I voluntarily consent to this testing and the disclosure of the test result as described above. A photocopy or facsimile of this form will be as valid as the original.

Name of Proposed Insured (*Print*)

Date of Birth

Signature of Proposed Insured or Parent, Guardian, or Health Care Agent

Date

Address

City, State, and Zip Code

**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 _____