North American Company
for Life and Health Insurance
Principal Office: 4601 Westown Pkwy, Suite 300
West Des Moines, IA 50266
A Member of the Sammons Financial Group

Clear Form Clear Kit

L177211

Reinstatement Application

Life Insurance Policy–Part A

Note: Complete the information and questions on this application on yourself, your spouse and children if they were also covered under the lapsed policy.	1. Payment Submitted: $	2. Policy Number:

3. Name of Insured: (Print full name)	4. Date of Birth:	5. Current Occupation: (Give title and duties)

6. Current Home Address:	City/Town	State	Zip Code	Phone Number ( )

7. a. Your Height?___ ft. ____in. Weight? _____ lbs. b. Have you lost over 10 lbs. in the past year? ☐ Yes ☐ No (if yes, give details in #10)
c. Name and address of your personal physician or health card facility: (if none, check here ☐ and omit d., e. and f.)

d. Date last consulted? e. Reason for consultation? f. Was any medication or treatment prescribed? ☐ Yes ☐ No
if yes, please describe

8. Since the date of the application of the lapsed policy, have you or any other person covered under the lapsed policy:	Yes	No
a. Been diagnosed or treated by a medical professional for heart disease, stroke, cancer, brain or mental disease, AIDS or HIV infection, alcohol or drug addiction, or diabetes?	☐	☐
b. Consulted, been examined or treated by any medical professional, or been admitted to or treated at a hospital or other care facility for any disease or condition not indicated in question 7 or 8a. above?	☐	☐

9. Have you or any other person covered under the lapsed policy:		
a. Any life insurance applications pending with any other company?	☐	☐
b. Been refused life or health insurance or reinstatement of life or health insurance within the past 3 years?	☐	☐
c. Been convicted in the past 3 years of a moving violation or driving under the influence of alcohol or drugs or had a drivers license suspended or revoked? (If Yes, give license no. and state in #10)	☐	☐
d. In the past 3 years, flown as a pilot or crew member or in any capacity other than fare paying passenger, or intend to do so in the future?	☐	☐
e. In the past 3 years, done any underwater diving, parachuting, sky diving, hang gliding, mountain climbing, cave exploration, vehicle racing of any kind or intend to do so in the future?	☐	☐
f. Any intention of traveling or residing outside of the U.S. or Canada?	☐	☐
g. Used tobacco in any form within the last 12 months?	☐	☐

10. Remarks: Give full details to all Yes answers including the name of the covered person and question number: (Use reverse side if more space is needed.)

Agreement – I (We) agree that: (1) All covered individuals named in the policy are now in good health except as set forth in this application; (2) All the statements and answers recorded on this application, including any required Part II, supplement or amendment are true and complete to the best of my(our) knowledge and belief and shall be the basis of any reinstatement granted; (3) That the policy shall not be reinstated until the Company has received all premiums due and approved this application at its Administrative Office during the lifetime of the Insured; (4) That the terms and conditions of the incontestable provision of the policy being reinstated shall apply to this application from the date the Company approved it.

Authorization – I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or any other organization, institution, or person that has any records or knowledge of me or my health or of any covered member of my family, to give to North American Company for Life and Health Insurance, or its reinsurers, any such information when given a copy of this authorization. This authorization is valid for twenty six months after I sign it and I know I can have a copy of it if desired.

Signed at _____ Date: _____
(City and State)

Insured: _____ Spouse: (if covered) _____

Witness: _____ Owner: _____
(if other than Insured)

Mail To: Administrative Office • P.O. Box 5088 • Sioux Falls, SD 57117-5088

L177212

(Read and retain for your records)

CONSUMER PROTECTION NOTICES FOR THE APPLICANT

Investigative Consumer Report Notice — In connection with your application for insurance, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may make a written request to be interviewed in connection with the preparation of this report. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation, Either of these written requests should be directed to the Underwriting Department, North American Company for Life and Health Insurance, P.O. Box 5088, Sioux Falls, SD 57117-5088.

MIB, Inc. Notice — Information regarding your insurability will be treated as confidential. North American Company for Life and Health Insurance, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request form you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

North American Company for Life and Health Insurance, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

These notices are to be detached and kept by the applicant.

L177213

Continuation of Reinstatement Application to
North American Company for Life and Health Insurance on: _____
Insured

Part B

11. Additional Remarks — Give additional details to any Yes answers if space is insufficient on Part A. Include the name of the covered person, the question number, full name and address of any doctors consulted and the date consulted.

Question No.	Details:

I (We) agree that; (1) All statements and answers recorded on this Part B of my (our) reinstatement application are true and complete to the best of my (our) knowledge and belief and shall form a part of my (our) reinstatement application, and; (2) They shall be subject to the terms of the Agreement on Part A of this application.

Signed at _____ Date: _____
(City and State)

Insured: _____ Spouse: (if covered) _____

Witness: _____ Owner: _____
(if other than Insured)