AURORA
AN RGA COMPANY
800-265-2652
PO Box 4336, Clinton, IA 52733-4336

APPLICATION FOR REINSTATEMENT

A. DETAILS OF PROPOSED INSURED

NAME OF PERSON TO BE INSURED		POLICY NUMBER
RESIDENCE ADDRESS OF PERSON TO BE INSURED (Used for underwriting information only. If a change of billings address is desired, use Section E.)		
DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER
HOME PHONE NUMBER	WORK PHONE NUMBER	DRIVERS LICENSE NO. AND STATE (If none, explain in Section E)
OCCUPATION		EMPLOYER

B. GENERAL QUESTIONS OF THE PROPOSED INSURED

1. Do you now or do you intend to engage in:
   a. any aviation activity other than as a fare paying passenger on commercial airlines? ☐ Yes ☐ No
   b. hazardous sports or activities such as motor racing in any form, skin or scuba diving, hang gliding, parachuting, mountain climbing, bungie jumping or rodeo? ☐ Yes ☐ No
2. Have you any intention of living or working outside the United States of America for more than 30 days? ☐ Yes ☐ No
3. Have you, within the past 5 years, had your drivers license suspended or revoked or been convicted of driving while under the influence of drugs or alcohol? ☐ Yes ☐ No

C. MEDICAL QUESTIONS OF THE PROPOSED INSURED

HEIGHT	WEIGHT	Has your weight changed by more than 10 pounds in the past 12 months? ☐ Yes ☐ No
NAME AND ADDRESS OF YOUR PERSONAL PHYSICIAN		
DATE AND REASON FOR LAST VISIT		DIAGANOSIS, MEDICATION AND TREATMENT PLAN

1. Are you presently taking any medication or receiving treatment of any kind? ☐ Yes ☐ No
2. Have you ever been treated for or diagnosed as having:
   a. chest pain, high blood pressure, heart attack, stroke or other disorder of the heart or blood vessels? ☐ Yes ☐ No
   b. diabetes, high blood sugar, cancer, tumor, or disorder of the liver? ☐ Yes ☐ No
   c. dizziness, fainting, convulsions, loss of balance, falling, paralysis, memory loss or any mental or nervous disorder? ☐ Yes ☐ No
   d. anemia, any disorder of the lymph nodes or glands, AIDS, or ARC? ☐ Yes ☐ No
3. Have you been advised to have any test, treatment, or surgery which has yet to be completed? ☐ Yes ☐ No
4. In the past 5 years, have you received treatment because of your use of alcohol or drugs? ☐ Yes ☐ No
5. In the past 12 months, have you used any form of tobacco or nicotine (including nicotine gum or nicotine patches)? ☐ Yes ☐ No

PROVIDE DETAILS OF ALL "YES" ANSWERS IN SECTION E

CONTINUED ON REVERSE SIDE

D. OTHER INSURANCE ON THE LIFE OF THE PROPOSED INSURED

1. Is there any other life insurance now in force on your life or is any application now pending? ☐ YES ☐ NO
If YES, please complete the following table.

Name of Company	Amount of Life Insurance	Year Issued	Premium Class

2. Have you, within the past two years, had an application for life insurance turned down, declined or offered with an extra premium? ☐ YES ☐ NO

3. Do you intend to replace any existing life insurance or annuity if this reinstatement is approved? ☐ YES ☐ NO

E. DETAILS OF "YES" ANSWERS (If additional space is needed, attach a separate declaration.)

Question	Details

F. DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I declare that each answer given to the questions contained in this application is complete and true to the best of my knowledge and belief. I understand and agree that the Company will rely on these answers, and the answers and statements I may give in any other form taken as a part of this application. I also understand that the Company reserves the right to accept or deny this application after taking into account whatever information may be available to it, including availability as to coverage by its reinsurers. I further agree that the policy shall not be considered in force until written approval is given by the Company and all overdue premium, together with any interest due, is received at the Home Office. I acknowledge that the Disclosure Notice has been given to me.

I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, the MIB, Inc. ("MIB"), consumer reporting agency or employer to give to Aurora National Life Assurance Company any information they might have regarding the diagnosis, treatment and prognosis of any physical or mental condition, my driving record, avocations or credit history. I also authorize the Company to obtain an investigative consumer report on me. To facilitate rapid transmission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

I agree that this authorization shall remain in effect for two and one half years from the date that it is signed and that a copy of it shall be as valid as the original. I understand that the information obtained with this authorization will be used to evaluate my application for insurance or to evaluate a claim during the time that this authorization is valid. I also understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization.

☐ If an investigative consumer report is prepared in connection with this application, I elect to be interviewed.

SIGNATURE OF POLICY OWNER (If not the Insured) ■	SIGNATURE OF PROPOSED INSURED ■	
WITNESS (or Licensed Resident Agent if required by law)	DATE	
PRINT NAME OF AGENT	AURORA AGENT NUMBER	AGENT PHONE NUMBER
DO YOU, THE AGENT, HAVE ANY REASON TO BELIEVE THAT THIS POLICY WILL REPLACE ANY OTHER LIFE INSURANCE OR ANNUITY? ☐ YES ☐ NO	STATE LICENSE NUMBER (if required by law)	

CONTINUED FROM REVERSE SIDE

Authorization for Release of Health Related Information to
Aurora National Life Assuarnce Company

This authorization complies with the HIPAA Privacy Rule.

________________	____	______/______/______
Policy Number	Name of proposed insured/patient (please print)	Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers") to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Aurora National Life Assurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

I also authorize any insurance or reinsuring company, the MIB, Inc. ("MIB"), or any other consumer reporting agency; or insurance support organization that has any personal medical information of mine or my minor children to release such information, including the entire medical record without restriction if requested, to the Company, its agents, employees and representatives. I also authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

The Company may use and disclose information received under this Authorization to 1) underwrite my application for coverage and 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 the Company. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

This Authorization shall remain valid for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original.

I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company at P.O. Box 4336, Clinton, IA 52733-4336. A revocation of this Authorization is not effective to the extent that the Company or others have relied on it, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I have received a copy of this Authorization, which I have signed and will retain for my records.

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Signature of Proposed Insured/Patient or Legal Representative   Date

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Description of Legal Representative's Authority or Relationship to Patient

Authorization for Release of Health Related Information to
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Policy Number	Name of proposed insured/patient (please print)	Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically-related facility, federally assisted alcohol or substance abuse program, Veterans Affairs health care facility, or other health care provider or facility that has provided payment, treatment, or services to me or on my behalf or the behalf of me and my minor children who are insured or for whom I am seeking insurance, if any, ("My Providers") to disclose the entire medical record and any other protected health information concerning me or me and my minor children to Aurora National Life Assurance Company ("the Company") and its agents, employees, and representatives. This includes information on the testing, diagnosis, treatment or prognosis of any physical or mental condition, including, but not limited to, Human Immunodeficiency Virus (HIV) infection and AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted or communicable diseases, mental illness, developmental disabilities, sickle cell anemia, and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with My Providers to restrict my or my minor children's protected health information do not apply to this Authorization. I further instruct My Providers to release and disclose my/our entire medical records without restriction, if requested under this Authorization.

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Description of Legal Representative's Authority or Relationship to Patient