RE

Application for Reinstatement of **Life Insurance** Policy

LIBERTY LIFE INSURANCE COMPANY, Greenville, S.C.

Policy Number

Branch Office/Agency

Application is made for reinstatement of the above numbered policy which lapsed by failure to pay premium due

1. Name of Insured (First) (Middle) (Last) Date of Birth State of Birth Age

2. Address of Insured (Street) (City) (State) (Zip)

3. If Policy includes Nominator Benefits:
   Name of Nominator

4. Names of any other Persons covered in policy. Age

   _____ _____

   _____ _____

   _____ _____

   _____ _____

5. Has an application for insurance, or reinstatement of insurance, on the life of any person named above ever been Declined or Rated? **(If "yes," give date and particulars.)**

6. Since Date of Issue of this policy, has any person named above:
   (a) Had any surgical operation, illness or injury? **(If "yes," give particulars, including dates and name of physician.)**

   (b) Consulted or been treated by any physician, clinic, hospital or other institution? **(If "yes," give particulars, including dates and name of physician or institution.)**

7. Name and Address of
   Family Physician

8. Has any person named used tobacco in any form within the past twelve months? ☐ Yes ☐ No
   Name of user? _____ Type Tobacco? _____ Amount used daily? _____

9. Has any person named ever flown or intended to fly as a pilot or crew member of any airplane? ☐ Yes ☐ No

I hereby represent to the best of my knowledge and belief that all statements and answers to questions in the application are complete and true, shall be treated as material to the risk, and have been made by me to induce the Company to reinstate the policy.

I hereby agree that the company may deposit in bank any cash, check, draft or money order which may be tendered in connection with this application, pending action hereon by the Company at its Home Office, that the policy shall not be reinstated unless and until, during the lifetime of each person named above and while the health and all other conditions affecting the insurability of each such person remain as stated in this application, the Company has approved at its Home Office this application and payment has been made of required past due premiums, and that if this application is declined, the return of any sum paid in connection with this application will be accepted and the Receipt given in exchange for such sum paid will be surrendered to the Company.

I hereby authorize any licensed 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 or my health, or of any member of my family proposed for insurance hereunder, to give Liberty Life Insurance Company or its reinsurers any such information; and agree to a medical examination if required by the Company. A photographic copy of this authorization shall be as valid as the original.

I acknowledge receipt of "Notice of Proposed Insured" accompanying this application.

Dated at _____ this _____ dav of _____ 20 _____

_____ _____

Witness Signature of Insured

Home Telephone ( ) _____

Application for Reinstatement of **Accident** and **Sickness** Policy

LIBERTY LIFE INSURANCE COMPANY, Greenville, S.C.

Policy Number

Branch Office/Agency

Application is made for reinstatement of the above numbered policy which lapsed by failure to pay premium due

1. Name of Insured (First) (Middle) (Last) Date of Birth State of Birth Age

2. What is your Occupation? _____ 3. Nature of Duties? _____

4. Since date of issue of this policy, has any Covered Person: YES NO

(a) Had any illness or accident? **(If "yes," give details below)**..... ☐ ☐

(b) Been under the care of or consulted a physician or practitioner? **(If "yes," give details below)**..... ☐ ☐

(c) Been treated at or confined in any clinic, hospital or other institution? **(If "yes," give details below)**..... ☐ ☐

NAME	DETAILS OR REASON	DATE	DURATION	IN HOSPITAL	NAME AND ADDRESS OF PHYSICIAN AND HOSPITAL

5. Has any Covered Person made application for Life, Accident or Health Insurance which has been declined or postponed, or has any policy for such insurance been rated up, modified, cancelled or renewal refused? **(If "yes," give details.)**

6. Do you now have or ever had any condition affecting your health which is not covered in the preceding questions?

7. Does any Covered Person now have any other hospital, surgical or medical expense insurance in force or applied for? **If so, give names of companies and kind and amounts of coverage, including Daily Hospital Benefit.**

8. If any Covered Person becomes disabled, what is the total monthly indemnity to be received from all forms of insurance, including any disability income benefit provided in Life Insurance policies.

9. Name and Address of Family Physician

I have paid to _____ $ _____, and I have received the Company's Receipt No. _____ for the same, which Receipt is hereby accepted, subject to the terms and conditions of this application. I hereby declare that all statements and answers to questions in the application are complete and true, shall be treated as material to the risk, and have been made by me to induce the Company to reinstate the policy.

I hereby agree that the company may deposit in bank any cash, check, draft or money order which may be tendered in connection with this application, pending action hereon by the Company at its Home Office, that the policy shall not be reinstated unless and until, during the lifetime of each person named above and while the health and all other conditions affecting the insurability of each such person remain as stated in this application, the Company has approved at its Home Office this application and payment has been made of required past due premiums, and that if this application is declined, the return of any sum paid in connection with this application will be accepted and the Receipt given in exchange for such sum paid will be surrendered to the Company.

I hereby authorize any licensed 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 or my health, or of any member of my family proposed for insurance hereunder, to give Liberty Life Insurance Company or its reinsurers any such information; and agree to a medical examination if required by the Company. A photographic copy of this authorization shall be as valid as the original.

I acknowledge receipt of "Notice to Proposed Insured" accompanying this application.

Dated at _____ this _____ dav of _____ 20 _____

_____ Witness

_____ Signature of Insured

Liberty Life Insurance Company
PO Box 789 Greenville, South Carolina 29602-0789

MEDICAL INFORMATION BUREAU, INC. NOTICE

Liberty Life Insurance Company, its third-party administrators, or its reinsurers may make a brief report to the Medical Information Bureau, Inc. ("MIB") concerning factors that affect the insurability of any person for whom coverage is being requested. The MIB is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is: P.O. Box 105, Essex Station; Boston, Massachusetts 02112, telephone number (866) 692-6901, TTY (866) 346-3642, fax number (781) 461-2453.

Liberty Life, its third-party administrators, 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 has been submitted.

CONSUMER REPORT NOTICE

In compliance with the Fair Credit Reporting Act, (the "Act"), we are informing you that as part of our routine procedures an investigative consumer report including information as to character, general reputation, personal characteristics and mode of living may be made. Under the Act, you have the right to make a written request within a reasonable period of time to receive additional information about the nature and scope of this investigation, to request a personal interview in connection with the investigative consumer report, and to receive a copy of the report. The investigation (which may include personal interviews) concerns residence verification, marital status, number of children, economic status, employment, occupation, general health, habits, reputation and mode of living. If the application is for family insurance or any other type insurance on spouse or minor child, this notice is also being given to you as the representative of said spouse or minor child named in the application. You may also request from the consumer reporting agency a written summary of your rights under the Fair Credit Reporting Act.

NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you. Some will come from other sources. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission. We will also make such other disclosures as are permitted by law. You may access and request corrections to the information we collect about you. We hope that you will find this description of our information practices to be helpful. We take our responsibilities and your rights very seriously. A more detailed description of our information practices will be provided to you.

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS