Application for Reinstatement and Insurability Statement

Accordia Life and Annuity Company
P.O. Box 305027
Nashville, TN 37230-5027
Customer Contact Center – Tel: 877 462 8992 Fax: 800 351 0603

IMPORTANT NOTE: Please do not send reinstatement premium at this time. Once your application for reinstatement has been approved, the applicant will be notified of the premium that must be received prior to reinstating the policy. For purposes of this reinstatement application, the terms "you", "yours", and "I" refer to the individual Proposed Insured identified below. If this life insurance policy and any attached riders insure more than one life, each insured or covered person must complete a separate reinstatement application as a Proposed Insured.

INFORMATION ABOUT THE INSURED

Policy Number	Proposed Insured			Date of Birth (mm/dd/yy) / /
Address		Email Address		
City	State	Zip	Phone Number	
Current Occupation		Height ft. in.	Weight lbs.	

MEDICAL INFORMATION

Since the date of the original application or change to the application, have you:

1. Been diagnosed with, treated for, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
   a. Brain or nervous system. . . . ☐ Yes ☐ No
   b. Heart, blood vessels or circulatory system . . . ☐ Yes ☐ No
   c. Respiratory system. . . . ☐ Yes ☐ No
   d. Stomach, liver, intestines, rectum, pancreas or abdominal organs . . . ☐ Yes ☐ No
   e. Genito-urinary organs . . . ☐ Yes ☐ No
   f. Skeletal system . . . ☐ Yes ☐ No
   g. Eyes, ears, nose or throat. . . . ☐ Yes ☐ No
   h. Blood (except those related to Human Immunodeficiency Virus [AIDS virus]), skin, thyroid, lymph or other glands . . . ☐ Yes ☐ No
   i. Psychiatric or mental health disorder or disease . . . ☐ Yes ☐ No
   j. Gynecological disorders or diseases . . . ☐ Yes ☐ No
   k. Cancer, tumor, cyst or nodule . . . ☐ Yes ☐ No
   l. Sexually transmitted disorders or diseases (except those related to Human Immunodeficiency Virus [AIDS virus]) . . . ☐ Yes ☐ No
   m. Disorders or diseases of the immune system except those related to Human Immunodeficiency Virus (AIDS virus) . . . ☐ Yes ☐ No
2. Been treated, examined, or advised by a member of the medical profession within the last 5 years? . . . ☐ Yes ☐ No
   If yes, give details below.
3. Used any medications? . . . ☐ Yes ☐ No
4. Been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? . . . ☐ Yes ☐ No
5. Have you ever had, been told you had, or have you ever been treated for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-related complex) or AIDS related conditions? . . . ☐ Yes ☐ No

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NON MEDICAL QUESTIONS

1. a. Do you use any form of tobacco or nicotine based products? ☐ Yes ☐ No
   b. If no, have you used any form of tobacco or nicotine based products in the last five years? ☐ Yes ☐ No
   c. If yes, when did you last use tobacco or nicotine based products?
   Mo./Yr. Last Used: _____ Type:_____ Quantity:_____
2. Within the last 5 years, have you ever:
   a. Used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician? ☐ Yes ☐ No
   b. Received medical treatment or counseling for, or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No
3. Have you been declined, rated, or had coverage modified or reinstatement declined by another insurance company? ☐ Yes ☐ No
4. Have you engaged in or intend within the next 2 years to engage in aviation activities other than as a passenger? ☐ Yes ☐ No
5. Have you engaged in or intend within the next 2 years to engage in ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, under-water diving, or any such hazardous activity? ☐ Yes ☐ No
6. Have you had your driver's license restricted, suspended or revoked, or received a warning letter? ☐ Yes ☐ No
7. Have you ever plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug? ☐ Yes ☐ No
8. Have you plead guilty to or been convicted of any moving violation within the last 5 years? ☐ Yes ☐ No
9. Have you ever plead guilty to or been convicted of a felony or misdemeanor? ☐ Yes ☐ No
10. Have you, the owner, or beneficiary been a resident or citizen of, or an entity organized under the laws of, a country other than the U.S.? ☐ Yes ☐ No
11. Have you, the owner, or beneficiary established a residence outside the U.S. or Canada within the last 2 years or intend on establishing a residence outside the U.S. or Canada within the next 2 years? ☐ Yes ☐ No
12. Do you intend to travel within the next 2 years outside the U.S. or Canada? ☐ Yes ☐ No
13. Are you or is the owner or beneficiary a member of the Armed Forces or an active or reserve military unit or have any of you entered into a written agreement to become a member of the Armed Forces? ☐ Yes ☐ No

REPLACEMENT QUESTIONS

1. Will any existing annuity or life insurance be replaced or changed if this policy is reinstated? ☐ Yes ☐ No
2. Do you have any life insurance applications currently pending or do you plan to apply for new life insurance coverage with any other company? ☐ Yes ☐ No
3. What is the total amount of all existing life insurance on your life? $_____
4. Will you or anyone on your behalf, receive compensation if this policy is issued and/or reinstated? ☐ Yes ☐ No
5. Have you, or has anyone on your behalf, discussed or arranged for the sale or assignment of this policy or any beneficial interest in an entity that owns this Policy? ☐ Yes ☐ No
6. Will any person or entity, other than Accordia Life and Annuity Company, evaluate you in order to provide any form of life expectancy evaluation? ☐ Yes ☐ No
7. Will any portion of the initial or future premiums on this policy be paid or provided by anyone other than you, your family member, or your employer? ☐ Yes ☐ No

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REPLACEMENT QUESTIONS (continued)

8. Please provide your total household income $_____ and net worth $_____

9. Has the ownership or control of this Policy changed since it was originally issued? . . . . . ☐ Yes ☐ No

   If so, please explain why in the detail section below.

Details of questions answered "Yes." Identify details for each "Yes" response above. For questions (1)-(5) in the **Medical Information** section above, include the name/address and phone number of all doctors seen and reason for consultation. (Attach separate sheet if necessary, signed & dated by the Proposed Insured.)

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the Company, its reinsurers, or its authorized representatives, to obtain from any consumer reporting agency or employer one or more consumer reports including, but not limited to, a credit report about me, which may include information about my physical or mental health.

I understand that an investigative consumer report may be prepared in connection with this application. I authorize the Company, its reinsurers, or its authorized representatives, to prepare or obtain from any consumer reporting agency one or more investigative consumer reports about me. I understand that an investigative consumer report involves personal interviews with sources such as neighbors, friends, or associates, and may include information as to my character, general reputation, personal characteristics, and mode of living. I understand that I may request to be personally interviewed if an investigative consumer report is prepared or obtained in connection with this application. I further understand that, if an investigative consumer report is prepared or obtained, I have the right to request in writing, within a reasonable time, a complete and accurate disclosure of the nature and scope of the investigation, and a summary of my rights under the Fair Credit Reporting Act.

I authorize the Company, its reinsurers, or its authorized representatives, to release information obtained in connection with this application including, but not limited to, any consumer reports, investigative consumer reports, or personal health information to reinsurers, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be permitted or required by law, or as I may further authorize.

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT ACT, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**

AGREEMENTS AND REPRESENTATIONS

To the best of my knowledge and belief the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to Accordia Life and Annuity Company ("the Company"). A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the Owner agrees and the change is authorized in writing by an officer of the Company.

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AGREEMENTS AND REPRESENTATIONS (continued)

I understand that the life insurance policy and coverage will be reinstated only if and when all of the following are true: (1) the Company receives full and good settlement for the reinstated policy while the Proposed Insured is living; (2) the Proposed Insured is a risk insurable under the Company's rules, limits and standards for the amount of insurance and plan of insurance applied for (as determined by the Company's authorized Officers at its Home Office); and (3) the Proposed Insured is living, and the answers and statements in the application and any Supplements are, and continue to be, complete and true at the time of reinstatement.

SIGNATURES

I have reviewed and understand the information contained above in the "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, "Authorization to Obtain and Disclose Information" and "Important Information About the USA Patriot Act" sections.

I understand, acknowledge and agree that the Agent/Producer has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent/Producer has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent/Producer has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

I have not been involved with and I am not aware of: (1) any planned sale or assignment of this policy to a life settlement or viatical company, secondary market purchaser or investor; (2) any planned sale or assignment of any interest in a trust or entity that shall own or have an interest in this policy; or (3) any offer of money, future payments, "free insurance" or anything of value to any Owner, Proposed Insured or Beneficiary in connection with this application or policy.

I understand the Company and its affiliates, agents and Independent contractors may listen to or record telephone calls between me and its representatives without additional notice to me.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY, IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, EVEN IF UNINTENTIONAL, THE COMPANY HAS THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.

Signature of Proposed Insured (or signature of Insured's Personal Representative*)		
Signed at: City	State	Date Signed
Signature of Owner if other than the Proposed Insured	**Signature of Licensed Agent/Producer**	
If Owner is a Corporation, Business firm or Trust, print name and title of individual authorized to sign		
Signature of Authorized Signer	Title of Authorized Signer	

*If you are signing on behalf of the Proposed Insured, print your name and provide your signature below. Check the box that applies to the capacity in which you are signing. Please also provide documents verifying you are authorized to act on behalf of the Proposed Insured.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

Signature	Printed Name	Date Signed