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)

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

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 [illegible]

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

This authorization complies with the HIPAA Privacy Rule.

_____ _____ _____/_____/_____

Policy Number