I.D. #_____
POLICY #_____

FIDELITY SECURITY LIFE INSURANCE COMPANY

APPLICATION FOR REINSTATEMENT OF INSURANCE

Name(s) of Person(s) to Be Reinstated		Soc. Sec. Number	Date of Birth	Age	Sex	State of Birth	Height	Weight
Applicant:							ft. in.	lbs.
Spouse:							ft. in.	lbs.
Child:	Relationship						ft. in.	lbs.
Child:							ft. in.	lbs.
Child:							ft. in.	lbs.

Residence Address			Billing Address (if different from residence)		
City	State	Zip Code	City	State	Zip Code
Occupation	Describe Duties		Name of Employer		
Telephone No. Home ( ) _____			Business ( ) _____		

IMPORTANT: To apply for reinstatement, ALL QUESTIONS MUST BE ANSWERED FOR ALL PERSONS TO BE REINSTATED and DETAILS OF ALL "YES" ANSWERS MUST BE PROVIDED.

To the best of your knowledge and belief:

		Yes	No
1.	Within the past five years (or the period since your original effective date, whichever is shorter) has any person to be reinstated:		
	a. Been declined, postponed, rated or charged an extra premium for life, universal life, variable universal life, disability income, or medical expense insurance, or offered a policy different from that applied for, or been refused reinstatement or renewal of life, universal life, variable universal life, disability income, or medical expense insurance? (If "Yes," give reason.)	☐	☐
	b. Been in a hospital, clinic, or institution for examination, observation, diagnosis, operation or treatment?	☐	☐
	c. (1) consulted or been treated or examined by any other doctors or other practitioner?	☐	☐
	(2) now taking medication?	☐	☐
2.	Does any person now have or is receiving treatment for any abnormality, deformity, disease or disorder?	☐	☐
3.	Has any person applied for or are they now receiving Disability Benefits from any source?	☐	☐
4.	Within the past ten years has any person been diagnosed by or received treatment from a licensed physician for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune system disorder?	☐	☐
5.	Has any person used any form of tobacco in the past 12 months?	☐	☐

– Complete Reverse Side –

Give DETAILS of all "YES" answers to all questions. Specify name of person, disease or injury, dates, results of treatment, names and addresses of each doctor and each hospital.

Question #	First Name of Person	Exact Name of the Disease or Disorder	Onset (Mo/Yr)	Duration or Recovery Date	Type of Treatment or Surgery	Still Under Treatment?	Complete Name, Mailing Address & Telephone Number of Doctor and/or Hospital

Name, address and telephone number of current or regular doctor and when last seen:_____

_____

_____

The above representations are true to the best of your knowledge and belief. All persons applying for reinstatement adopt, as their own, the above representations. It is agreed that this coverage will not be reinstated and we will have no liability (other than to return payments made consequent to this application, without interest) until: (1) all money required for reinstatement of this coverage has been paid; and (2) this application has been approved by us at our Home Office during the lifetime of all persons who would be insured under this coverage if reinstated. It is agreed that the Date of Reinstatement will be as follows: the date of approval by us of the application for reinstatement. It is further agreed that reinstatement of this coverage, if granted by us, will be contestable for fraud or misrepresentation of any material facts stated in, or in connection with, this application may result in claim denial or rescission of coverage for two years after the Date of Reinstatement. If coverage is rescinded, the Company's only obligation for that person will be to refund all premiums.

I have received and read a copy of the Pre-Notice which describes how information is obtained and used by Fidelity Security Life Insurance Company.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or the Medical Information Bureau, Inc., that has any records or knowledge of me or my health {or my dependents health}, to give to Fidelity Security Life Insurance Company, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy.

A photographic copy of this authorization shall be as valid as the original.

I agree this authorization shall be valid for two years from the date shown below.

Date _____ Signature _____

Date _____ Signature of Spouse _____

Underwritten by: Fidelity Security Life Insurance Company, Kansas City, Missouri

{Mail application to: Fidelity Security Life Insurance Company, 1504 NW Mock Avenue • P.O. Box 1058 Blue Springs, Missouri 64013-1058, 1-888-219-8067}