Individual Life Insurance Application for Reinstatement with Evidence of Insurability

Interstate Compact states

Good Order Checklist: Use this checklist to make sure you have provided all the information required to evaluate your application for reinstatement. Complete and sign the forms in blue or black ink; do not use pencil or correction fluid. Do not send any payment with this application. Missing or incomplete information will lead to processing delays. **Note:** If the policy includes a joint Insured (i.e. survivorship policies), each Insured must complete their own Individual Life Insurance Application for Reinstatement with Evidence of Insurability package.

All signatures on this application must be physical signatures. We cannot process these requests if the application is signed using electronic signatures or signature fonts.

Forms contained in this package:

☐ ***Authorization for Release of Health-Related Information (HIPAA Compliant)***

Each insured must complete and sign his/her own form. Please make copies of the blank form if necessary.

☐ ***Individual Life Insurance Application for Reinstatement with Evidence of Insurability***

These sections are required to be completed by the Primary Insured and the Other Insured (second insured adult) if there is one:

- ☐ Part I-A. Reinstatement Request
- ☐ Part I-B. Primary Insured Information
- ☐ Part I-C. Other Insured Information: If there is only a Primary Insured, this section may be left empty.
- ☐ Part I-D. Personal History
- ☐ Part I-E. In Force/Replacement Information: Certain states require an additional form even if the insured(s) don't have another policy. See information about state-mandated replacement forms below.
- ☐ Part I-F. Financial Details
- ☐ Part I-I. Acknowledgements, Certifications, Authorizations and Representations

These sections should be completed only if applicable:

- ☐ Part I-G. Notes
- ☐ Part I-J. Agent Signatures: Agent completes this section if involved in the reinstatement request.

☐ ***Individual Life Insurance Application for Reinstatement with Evidence of Insurability Part II - Medical Declarations***

Must be completed and signed by the Primary Insured and Other Insured if there is one.

Forms you must call Customer Service to obtain:

☐ ***Questionnaires***

If you answered "yes" to questions numbered 1, 2, 3, 4, or 5 in Part I-D. Personal History, call Customer Service at 877-886-5050 and ask for the applicable questionnaire(s). Complete and sign the questionnaire(s) and return it with the application.

☐ ***State-mandated replacement form***

If you answered "yes," to question 1 in Part I - E. In force/Replacement Information, and if the Primary Insured or Other Insured lives in one of the following states: AK, AL, AZ, CO, CT, HI, IA, KY, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, SD, TX, UT, VA, VT, WI and WV, call Customer Service at 877-886-5050 and ask for the state-mandated replacement form. Complete and sign the form and return it with the application.

RESET FORM

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION *(HIPAA compliant)*

Security Life of Denver Insurance Company (SLD), Denver, CO
ReliaStar Life Insurance Company (RLIC), Minneapolis, MN
ReliaStar Life Insurance Company of New York (RLNY), Woodbury, NY
RLIC and RLNY ("RLSTR") affiliated
(the "Company")

SLD and RLSTR may provide administrative services to each other, but are otherwise unaffiliated. All contractual obligations under each insurance policy or contract are the sole responsibility of the issuing insurance company.

PROPOSED INSURED INFORMATION *(Please print.)*

Proposed Insured Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date *(mm/dd/yyyy)* _____

AUTHORIZATION INFORMATION

This will authorize a physician, clinic or hospital to release medical information to the Life Insurance Carrier(s) named above (the "Company"), or its reinsurers.

The information to be released or disclosed for the purpose of a life insurance application includes any and all health-related information and medical records, including chemical dependency/drug or alcohol abuse treatment records, pathology reports, radiology reports and films, and lab reports, within the past 10 years (unless otherwise provided by state law).

The purpose of this authorization is to assist in the evaluation and placement of my application for life insurance. I authorize any organization, insurance company or medically related facility to release to the Life Insurance Carrier named above any and all records and information regarding me, the proposed insured, and any minor children who are to be insured according to the terms of this authorization. This includes records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition. Some examples of the type of information to be released include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions or prescription records; (4) HIV testing and treatment (except where prohibited by law); (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or health care provider that has provided payment, treatment or services to me or on my behalf ("my providers") within the past 10 years (unless otherwise provided by state law) to disclose my entire medical record and any other protected health information concerning me to the Life Insurance Agent/Agency/Carrier(s) named above and its agents, employees, representatives and the insurance carrier(s) listed on this authorization. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I authorize MIB, Inc. to give to the Life Insurance Carrier(s) named above (the "Company"), or its reinsurers, any records or knowledge of me or my health.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

Protected health information is to be disclosed under this authorization so that the Life Insurance Agent/Agency/Carrier(s) may provide the information to the listed carrier(s) so that they may: 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 Life Insurance Agent/Agency/Carrier(s).

I give my permission to the Life Insurance Carrier named above to send any information obtained to MIB, Inc. or its reinsurers.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Life Insurance Agent/Agency/Carrier(s) named above at the following address: **Attention:** Privacy Official, 2000 21st Ave. NW, Minot, ND 58702

I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the insurance carrier(s) has a legal right to contest a claim under an insurance policy or to contest the policy itself. 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. Any re-disclosure continues to be covered by any applicable state privacy laws, state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance carrier(s) may not be able to process my Application or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Proposed Insured Signature _____ Date *(mm/dd/yyyy)* _____

Authorized Signer *(if Proposed Insured is a minor)* _____ Date *(mm/dd/yyyy)* _____

Description of Personal Representative's Authority or Relationship to Proposed Insured:

☐ Attorney in Fact ☐ Grandparent ☐ Guardian ☐ Parent ☐ Other _____

A COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PROPOSED INSURED.

INDIVIDUAL LIFE INSURANCE APPLICATION FOR REINSTATEMENT WITH EVIDENCE OF INSURABILITY

☐ **Security Life of Denver Insurance Company (SLD),** 7535 East Hampden Ave, Suite 400, Room 446, Denver, CO 80231
☐ **Midwestern United Life Insurance Company (MULIC),** 111 Monument Circle, Suite 2700, Indianapolis, IN 46204
SLD and MULIC ("SLD/MULIC") affiliated
☐ **ReliaStar Life Insurance Company (RLIC),** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Venerable Insurance and Annuity Company (Venerable),** 699 Walnut Street, Suite 1350, Des Moines, IA 50309
(the "Company")

Mail or fax all completed materials to Customer Service: PO Box 5065, Minot, ND, 58702-5065; **Fax to:** 877-788-3151

SLD/MULIC, RLIC and Venerable may provide administrative services to each other, but are otherwise unaffiliated. All contractual obligations under each insurance policy or contract are the sole responsibility of the issuing insurance company.

PART I - A. REINSTATEMENT REQUEST

(No other policy changes are permitted for reinstatement requests. If the policy is approved for reinstatement coverage and it included a Children's Insurance Rider, the policy will be reinstated with the Children's Insurance coverage as originally issued.)

Policy Number *(required for all requests)* _____

PART I - B. PRIMARY INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____
2. Birth Date _____ SSN _____ Birth State/Country _____ Gender: ☐ M ☐ F
3. Residence Address *(PO Boxes are not permitted.)* _____
   City _____ State _____ ZIP _____
4. Daytime Phone (_____)_____ Evening Phone (_____)_____
5. Best Time to Call _____ Email _____
6. Driver's License Number _____
   (If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)
7. Driver's License State _____
8. Name on Driver's License *(if different than above)* _____
9. Are you a U.S. Citizen? *(If "no," complete the Foreign Travel and Residence Questionnaire.)*. . . . . ☐ Yes ☐ No
10. Employer/Occupation/Duties *(If self-employed, duties should also be listed.)* _____
    _____
11. Do you currently use or have you ever used tobacco or nicotine products in any form? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, nicotine patches, hookah or vaping)* . . . . . ☐ Yes ☐ No
    If "yes," indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____

PART I - C. OTHER INSURED INFORMATION

*(Only complete this section if there is another adult covered under this policy. The Other Insured **does not** refer to children that may be covered by the Children's Insurance Rider.)*

1. First Name _____ MI _____ Last Name _____
2. Birth Date _____ SSN _____ Birth State/Country _____ Gender: ☐ M ☐ F
3. Residence Address *(PO Boxes are not permitted.)* _____
   City _____ State _____ ZIP _____
4. Daytime Phone (_____)_____ Evening Phone (_____)_____
5. Best Time to Call _____ Email _____
6. Driver's License Number _____
   (If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)
7. Driver's License State _____
8. Name on Driver's License *(if different than above)* _____
9. Are you a U.S. Citizen? *(If "no," complete the Foreign Travel and Residence Questionnaire.)*. . . . . ☐ Yes ☐ No

PART I - C. OTHER INSURED INFORMATION *(Continued)*

10. Employer/Occupation/Duties *(If self-employed, duties should also be listed.)* _____

_____

11. Do you currently use or have you ever used tobacco or nicotine products in any form? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, nicotine patches, hookah or vaping)* . . . . . ☐ Yes ☐ No

If "yes," indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____

PART I - D. PERSONAL HISTORY *(Questions 1-7 must be completed for the Primary Insured and Other Insured. If you answer "yes" to any of questions 1-5, call Customer Service to obtain the appropriate Questionnaires listed below.)*

	Primary Insured		Other Insured	
1. Are you, or have you entered into a written agreement to become, a member of the armed forces, including the Reserves? ***(If "yes," complete the Military Questionnaire.)***	☐ Yes	☐ No	☐ Yes	☐ No
2. Do you intend to travel or reside outside the United States or Canada in the next two years? ***(If "yes," complete the Foreign Travel and Residence Questionnaire.)***	☐ Yes	☐ No	☐ Yes	☐ No
3. Have you in the last five years made, or do you anticipate in the next two years making flights, in an aircraft OTHER than as a passenger on a scheduled airline? ***(If "yes," complete the Aviation Questionnaire.)***	☐ Yes	☐ No	☐ Yes	☐ No
4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, or rodeos? ***(If "yes," to scuba diving, complete Scuba Diving Questionnaire. For any other "yes," complete Avocations and Professional Sports Questionnaire.)***	☐ Yes	☐ No	☐ Yes	☐ No
5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes or dune buggies? ***(If "yes," complete Avocations and Professional Sports Questionnaire.)***	☐ Yes	☐ No	☐ Yes	☐ No
6. Except for traffic violations, have you been convicted in a criminal proceeding or are criminal charges against you currently pending?	☐ Yes	☐ No	☐ Yes	☐ No
7. Have you in the last five years had any motor vehicle accidents in which you were found at fault, alcohol or drug-related convictions, or been convicted of any moving violation of a motor vehicle?	☐ Yes	☐ No	☐ Yes	☐ No

For any "yes" answer to questions 6-7, please record information in the chart below.

Question	Primary Insured / Other Insured Name	Explanation

PART I - E. IN FORCE/REPLACEMENT INFORMATION *(This section must be completed for all Insureds.)*

	Primary Insured		Other Insured	
1. Do you currently have life insurance in force or applied for? *(If "yes", provide details below. Also, if you live in one of these states: AK, AL, AZ, CO, CT, HI, IA, KY, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, SD, TX, UT, VA, VT, WI and WV, call Customer Service to obtain the state-mandated replacement form.)*	☐ Yes	☐ No	☐ Yes	☐ No

Primary Insured / Other Insured Name	Insurance Company *(Do not include group policies.)*	Policy Number	Amount	Date Issued
			$	
			$	

	Primary Insured		Other Insured	
2. Are you considering using funds from your existing policies or contracts to pay premiums due on this policy or contract? *(If "yes," complete state required replacement form and provide details below.)*	☐ Yes	☐ No	☐ Yes	☐ No
3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? *(If "yes," complete state required replacement form and provide details below.)*	☐ Yes	☐ No	☐ Yes	☐ No

4. For any "yes" answer to questions 2-3, provide details regarding the policies being replaced or changed in the chart below.

Insured Name	Insurance Company	Policy Number	Amount
			$
			$

PART I - F. FINANCIAL DETAILS *(This section is required for the Primary Insured and the Other Insured for all requests.)*

1. Is the policy in accordance with your insurance objectives and your anticipated financial needs? . . . . . ☐ Yes ☐ No
2. Do you believe you have the financial ability to continue making premium payments on this policy? . . . . . ☐ Yes ☐ No
3. Have you or your company ever declared bankruptcy? ***(If "yes," provide details, type and date discharged below.)*** . . . . . ☐ Yes ☐ No

a. Details _____

b. Bankruptcy Type _____

c. Bankruptcy Discharge Date _____

4. Complete the table below for the Primary Insured and Other Insured.

	Annual Earned Income	Annual Interest and Other Income	Total Assets	Total Liabilities	Total Net Worth
Primary Insured	$	$	$	$	$
Other Insured	$	$	$	$	$

PART I - G. NOTES *(Use this space to provide additional details to questions answered in the application. Information provided below will be considered part of your Individual Life Insurance Application for Reinstatement with Evidence of Insurability. If you need more space, attach a separate piece of paper to the application.)*

Section	Question	Details

PART I - H. STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI) POLICY

The Company strongly opposes arrangements designed to obtain life insurance for the benefit of a third party (a "stranger") that has no insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. We believe this position supports the best interests of our policy owners, as stranger-owned or stranger-originated life insurance transactions ("STOLI") will lead to higher costs for consumers and undermine the concept of insurable interest, a core element of the life insurance business. The Company will seek to terminate the insurance coverage under any contract determined to be STOLI or where material misrepresentation has occurred regarding the facts presented to the Company for underwriting the application. Attempts to defraud the Company may result in additional legal action.

The Company does not sell life insurance in the following circumstance:

- If, at the time of sale or conversion, the applicant/owner has an intent, plan, arrangement or understanding with a third party that will result directly or indirectly in the sale, assignment, settlement or other transfer to an investor, such as a life settlement company, or any other party with no insurable interest in the life of the insured who purchases the policy for investment purposes;
- If, at the time of sale or conversion, the applicant/owner has an intent, plan or arrangement to transfer an ownership interest or beneficial interest in an entity that will own the policy to a life settlement company or any other party with no insurable interest in the life of the insured;
- If, in connection with the sale, the applicant/owner and/or the insured is offered any compensation, reward or benefit, or other inducement to purchase or assist in the purchase the policy, including, but not limited to, cash payments, property such as a life insurance death benefit for "free" or at "no cost" or any other benefit of any kind;
- Where a sales concept, design, marketing plan, marketing material or other program that has not been disclosed to the Company is used in connection with the sale (including, but not limited to, any nontraditional premium finance program, such as "non-recourse" lending arrangement where the lender's sole collateral for the premium loan is limited to the values of the policy itself);
- Where the producer and/or applicant knows, or has reason to know, that the source of funds for premium payments under a policy has not been disclosed to the Company (including, but not limited to, any arrangement to pay for premiums under the policy through a loan through a premium financing arrangement or other third party funding) ; or
- In any other circumstance determined by the Company, in its sole discretion, to be inconsistent with our policies on STOLI, insurable interest or misrepresentation.

The activities described above are considered "prohibited conduct".

PART I - I. ACKNOWLEDGEMENTS, CERTIFICATIONS, AUTHORIZATIONS AND REPRESENTATIONS

Acknowledgements and Agreement: By signing this application, I acknowledge and agree that:

1. **Incontestability.** If the policy is reinstated, the date for the purpose of incontestability and the suicide exclusion shall be the date of this reinstatement application.
2. **Application:** I have read this application and I agree with the statements in this application. This application will be attached to and become part of the policy.
3. **Rescission for False Statements:** The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully including without limitation, financial, employment and medical information.
4. **Information Limited to Application.** This application consists of all pages of the Application, the Additional Statement to Application, appendices, and supplemental questionnaires. It will be the basis for any reinstatement approved and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein.
5. **Company's Liability for Insurance Coverage.** No reinstatement shall be in force until: (a) any required payment for the request is paid in full, and (b) the request is approved by the Company while the facts and health condition of those to be insured remain the same as represented in this application. Even if the Company accepts payment made with this application, it may decline the request. The Company may require additional evidence of insurability before approving this request.

PART I - I. ACKNOWLEDGEMENTS, CERTIFICATIONS, AUTHORIZATIONS AND REPRESENTATIONS *(Continued)*

6. **No Waiver by Producer.** The producer does not have the authority to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements.
7. **Signature.** By signing this application, I am applying for a reinstatement of life insurance coverage issued by the Company.
8. **Receipt of Disclosure and Forms.** I received the following disclosures and notices: Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices.

Certification. By signing this application, I certify, under penalty of perjury, that my Social Security Number / Tax Identification Number is shown and is correct and that I am not subject to back-up withholding.

Authorizations: By signing this application, I make the following authorizations:

1. **Collection of Medical Record Information or Investigative Reports.** I authorize the Company and other insurance companies affiliated with the Company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this application.
2. **Release of Records.** I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied. I authorize MIB, Inc. to give to the Life Insurance Carrier(s) named above, or its reinsurers, any records or knowledge of me or my health. I understand that this authorization will be valid for 24 months from the date of signature on this application unless the applicable law of the state where this policy is delivered or issued for delivery provides for a shorter period of time, in which case, that state's law shall apply. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original.
3. **Investigative Consumer Reports.** If an investigative consumer report is prepared, I request to be interviewed. ☐ Yes
   Daytime phone number: (_____)_____.
   Contact me between the hours of _____ a.m./p.m. and _____ a.m./p.m.

Representations. By signing this application, I represent that:

1. All questions have been truthfully answered to the best of my knowledge and belief.
2. The policy is not STOLI and I have not engaged in any prohibited conduct as described in Section H above.
3. I agree to inform the Company of any known material change in health of the Proposed Insured(s) prior to delivery of the Policy.

All completed materials must be sent to Customer Service at: PO Box 5065, Minot, ND, 58702-5065

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

In what city and state did the **Owner** sign this application? *(City)* _____ *(State)* _____

➥ Owner Signature *(if other than the Insured)* _____ Date _____

Owner/Trustee Name *(Please print.)* _____

➥ Primary Insured Signature *(if age 15 or older)* _____ Date _____

➥ Other Insured Signature _____ Date _____

➥ Parent or Guardian Signature _____ Date _____
(if the Owner, Primary Insured or the Other Insured is a minor)

PART I - J. AGENT SIGNATURES *(This section is only required if an agent was involved in your Reinstatement Request.)*

By signing below I acknowledge that I have not engaged in prohibited conduct as described in Part I - H, "Stranger-Owned or Stranger-Originated Life Insurance (STOLI) Policy," nor am I aware of such conduct by the applicant.

➥ Writing Agent/Registered Rep. Signature _____ Date _____

Writing Agent State Lic. Number _____ Writing Agent/Registered Rep. Number _____

Agent/Registered Rep. Name _____

Agent State Lic. Number _____ Agent/Registered Rep. Number _____

CUSTOMER SERVICE USE ONLY

Endorsed by _____ Date _____ Effective Date _____

Endorsed by _____ Date _____ Effective Date _____

INDIVIDUAL LIFE INSURANCE APPLICATION FOR REINSTATEMENT WITH EVIDENCE OF INSURABILITY: PART II - MEDICAL DECLARATIONS

☐ **Security Life of Denver Insurance Company (SLD),** 7535 East Hampden Ave, Suite 400, Room 446, Denver, CO 80231
☐ **Midwestern United Life Insurance Company (MULIC),** 111 Monument Circle, Suite 2700, Indianapolis, IN 46204
SLD and MULIC ("SLD/MULIC") affiliated
☐ **ReliaStar Life Insurance Company (RLIC),** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Venerable Insurance and Annuity Company (Venerable),** 699 Walnut Street, Suite 1350, Des Moines, IA 50309
(the "Company")
Mail or fax all completed materials to Customer Service: PO Box 5065, Minot, ND, 58702-5065; **Fax to:** 877-788-3151

SLD/MULIC, RLIC and Venerable may provide administrative services to each other, but are otherwise unaffiliated. All contractual obligations under each insurance policy or contract are the sole responsibility of the issuing insurance company.

Complete Part II - Medical Declarations for the Primary Insured and Other Insured who are covered by this policy. If you answer "yes" to questions 17 or 18, provide details in section 20 on page 2 of the Medical Declarations.

Primary Insured Name _____ Policy Number _____

Other Insured Name _____

Primary Insured

1. Height *(feet and inches)* _____ Weight _____ Change in weight in the last year ☐ Gain ☐ Loss ☐ No change
2. Amount of weight gained or lost in the past year, and reason for the change _____
3. Primary Physician/Facility Name _____ Primary Physician/Facility Phone (_____)_____
4. Primary Physician/Facility Address _____
   City _____ State _____ ZIP _____
5. Date last seen by Physician _____
6. Reason for Consultation _____
7. Results of Consultation _____

Other Insured

8. Height *(feet and inches)* _____ Weight _____ Change in weight in the last year ☐ Gain ☐ Loss ☐ No change
9. Amount of weight gained or lost in the past year, and reason for the change _____
10. Primary Physician/Facility Name _____ Primary Physician/Facility Phone (_____)_____
11. Primary Physician/Facility Address _____
    City _____ State _____ ZIP _____
12. Date last seen by Physician _____
13. Reason for Consultation _____
14. Results of Consultation _____

15. Family History

	Primary Insured				Other Insured		
	Age if Living	Age at Death	Cause of Death		Age if Living	Age at Death	Cause of Death
Father				Father			
Mother				Mother			

	Primary Insured	Other Insured
16. Are you presently taking any medication(s), including non-prescription/over the counter medication or supplements? *(If "yes," provide name, dosage/frequency, prescribing doctor's name and address, and reason in the table below.)*	☐ Yes ☐ No	☐ Yes ☐ No

Medication Name	Dosage/Frequency	Prescribing Doctor's Name and Address	Reason

MEDICAL DECLARATIONS *(Continued)*

	Primary Insured	Other Insured
17. In the past 10 years, have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("health care provider") as having:		
a. Dizziness, seizures, convulsions, headache, paralysis, stroke, transient ischemic attack (TIA or brain ischemia), or a mental or nervous disorder, including anxiety or depression?	☐ Yes ☐ No	☐ Yes ☐ No
b. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?	☐ Yes ☐ No	☐ Yes ☐ No
d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or other disorder of the stomach, intestine, liver, pancreas, or gall bladder?	☐ Yes ☐ No	☐ Yes ☐ No
e. Sugar, albumin, or blood in urine, sexually transmitted disease, nephritis, stone, or other disorder of the kidneys, bladder, breasts, prostate, or reproductive organs?	☐ Yes ☐ No	☐ Yes ☐ No
f. Diabetes, thyroid, or other endocrine disorder?	☐ Yes ☐ No	☐ Yes ☐ No
g. Disorder of the skin or lymph glands, arthritis, or any disorder of the muscles, joints, nerves or bones?	☐ Yes ☐ No	☐ Yes ☐ No
h. Anemia or any other disorder of the blood?	☐ Yes ☐ No	☐ Yes ☐ No
i. A positive HIV test, AIDS (Acquired Immunodeficiency Syndrome), or any other disease or disorder of the immune system?	☐ Yes ☐ No	☐ Yes ☐ No
18. Have you:		
a. Had any operation(s) in the past 5 years?	☐ Yes ☐ No	☐ Yes ☐ No
b. In the past 5 years been advised by a member of the medical profession to have operation(s), treatments, or diagnostic tests that have not yet been performed (excluding HIV testing)?	☐ Yes ☐ No	☐ Yes ☐ No
c. Had an electrocardiogram, x-ray, or other diagnostic test in the past 5 years (excluding HIV testing)?	☐ Yes ☐ No	☐ Yes ☐ No
d. In the past 5 years been confined for observation, care, or treatment in a hospital or other health care facility?	☐ Yes ☐ No	☐ Yes ☐ No
e. In the past 5 years, been treated, examined or advised by a member of the medical profession not already identified, for any reason including routine physical examination?	☐ Yes ☐ No	☐ Yes ☐ No
f. Sought or been advised by a health care provider to seek advice or treatment for the use of alcohol or drugs? ***(If "yes," complete Alcohol Usage or Drug Use Questionnaire.)***	☐ Yes ☐ No	☐ Yes ☐ No
g. Ever been diagnosed by a health care provider as having a tumor, pre-cancerous lesion or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
19. Are you currently using or have you ever used Ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider? ***(If "yes," complete Drug Use Questionnaire.)***	☐ Yes ☐ No	☐ Yes ☐ No

20. For any "yes" answer to questions 17 or 18 please record information in the chart below.

Question	Primary Insured / Other Insured Name	Condition/Diagnosis	Dates/Duration of Condition/ Treatment & Test Results	Physician/Facility Name, Address & Phone

I have read the statements above and affirm that they are complete and true to the best of my knowledge and belief.

Signed at *(city, state)* _____

Primary Insured Signature *(if age 15 or older)* _____ Date _____

Other Insured Signature _____ Date _____

Parent or Guardian Signature *(if the Primary Insured is a minor)* _____ Date _____

IMPORTANT NOTICES

Security Life of Denver Insurance Company (SLD), Denver, CO
Midwestern United Life Insurance Company (MULIC), Indianapolis, IN
SLD and MULIC ("SLD/MULIC") affiliated
ReliaStar Life Insurance Company (RLIC), Minneapolis, MN
Venerable Insurance and Annuity Company (Venerable), Des Moines, IA
(the "Company")

SLD/MULIC, RLIC and Venerable may provide administrative services to each other, but are otherwise unaffiliated. All contractual obligations under each insurance policy or contract are the sole responsibility of the issuing insurance company.

CONSUMER PRIVACY NOTICE

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. If you wish, the Company ("we") will send you the name, address, and phone number of any agency we ask to prepare a consumer report about you. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records or by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with the Company unless you request otherwise.

The information may be kept by the consumer reporting agency. It may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; and your state's Insurance Information and Privacy Protection Act, if any. The agency will give you a copy of the report if you ask for one and provide the proper identification.

Notice Regarding MIB, Inc.
(Medical Information Bureau)

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, a nonprofit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another MIB, Inc. member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The mailing address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The phone number is 866-692-6901 and the fax number is 866-346-3642. The MIB, Inc. website address is www.mib.com.

THIS PAGE MUST BE GIVEN TO THE INSURED.

CONSUMER PRIVACY NOTICE *(Continued)*

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Federal Regulations - 42CFR Part 2

Your medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. If information is protected by federal or state law, you may revoke this authorization at any time by mailing a written request to the Company. A written request, however, will not apply to any information collected before the date that we receive your request.

IMPORTANT INFORMATION

To help the government fight the funding for terrorism and money-laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you apply for life insurance, we will ask for your name, address, birth date, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

If you wish to have a more detailed explanation of our information practices, please write to:

Customer Service
Life Policy Owner Services, PO Box 5065
Minot, ND, 58702-5065

ACKNOWLEDGEMENTS

Notice Regarding Collection of Information and Information Practices

In order to evaluate your application for life insurance, we must collect information about you. The type of information that we may collect includes, but is not limited to, the following: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; any non-medical information about you. Some of that information will come from you. Some will come from other sources.

The sources that we may contact for information include, but are not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically related facilities, insurance or reinsuring companies, Medical Information Bureau ("MIB"), Inc., any consumer reporting agencies, and any other organizations. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission.

You have a right to access and correct the information collected about you. This right does not extend to information that relates to a claim or civil or criminal proceeding. You have the right to receive, in writing, the reasons for any adverse underwriting decisions.

Insured/Owner: ***By signing Part I - I on the Individual Life Insurance Application for Reinstatement with Evidence of Insurability, the Insured acknowledges receipt of these notices.***

Producer: By signing Part I - I on the Individual Life Insurance Application for Reinstatement with Evidence of Insurability, the producers acknowledge that a copy of these notices have been provided.

THIS PAGE MUST BE GIVEN TO THE INSURED.