WILLIAM PENN LIFE INSURANCE
COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 346-4773

Reinstatement Application

Instructions:

To expedite processing of your reinstatement application, please complete the accompanying Reinstatement Application in its entirety.

- All questions must be answered and details provided if required
- Failure to provide **ALL** details and complete **ALL** questions on the application will result in delaying your request to restore your coverage

Additional Information Section

- Provide details for any question(s) you answered yes
- Provide the date of your last visit to your physician and the reason for the visit

Authorization Section

- Sign and Date where indicated
- Provide email address to expedite the review process

Please submit the completed form to our Administrative Office:
William Penn Life Insurance Company of New York
3275 Bennett Creek Avenue
Frederick, Maryland 21704
Fax: 516-229-3081
Email: customerservice@wpenn.com

What you can expect

Upon review of your reinstatement application, we may request additional medical testing and records. Should such records or testing be necessary you will be advised on how to schedule this additional testing through a trusted third party vendor **(Any medical records or examination requirements will be at your expense).**

Upon receiving all required information, we will evaluate your policy. **Policy reinstatement may take up to 6 weeks or longer depending on the requirements needed and how quickly you respond to our request for additional information.**

If approved, the required premium amount to reinstate your policy will be requested.

Should you have any questions or require additional information please contact us at 1-800-453-7366 or customerservice@wpenn.com.

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APPLICATION FOR REINSTATEMENT

This application must be completed in its entirety and properly signed. Each Insured covered by the policy is to complete an Application for Reinstatement, answering each of the following questions. Explain any "Yes" answers on page 3 of this form. Please print.

Policy Number _____

Name of Insured _____ Best Contact Number _____

Address _____

Email address _____

Name of Policy Owner _____ Phone Number _____
(If other than Named Insured)

Address _____

Answer all questions for the time period beginning with the date of the original application to the current date.

PHYSICIAN INFORMATION

1. **Primary Physician (if none, state none)**

   Name _____

   Address _____

   Telephone _____ Date last seen _____

   Reason last seen and results of visit _____

2. **Physician Last Consulted (if none, state none)**

   Name _____ Specialty _____

   Address _____

   Telephone _____ Date last seen _____

   Reason last seen and results of visit _____

3. Height: _____ft. _____in.

4. Weight: _____lbs. If your weight has changed by over 10 lbs. in the last year, indicate amount and reason: _____

Provide details to Yes answers in the Additional Information section. Include provider, date, symptoms, diagnosis and treatment. An additional sheet of paper may be attached if necessary.

	Yes	No
5. Do you have a driver's license or state ID? ..... If Yes, provide driver license or state ID number and state of issue _____	☐	☐
6. In the past 5 years has your driver's license been suspended or revoked, or have you been convicted of 2 or more moving violations or accidents?	☐	☐
7. Has a parent or sibling been diagnosed or treated by a member of the medical profession for heart or kidney disease, stroke, diabetes, cancer, melanoma, suicide, Huntington's Disease, Sickle Cell Disease or Familial Adenomatous Polyposis (FAP)? If Yes, give details in the Additional Information section.	☐	☐

Questions 8-23, have you consulted a member of the medical profession regarding or have you been diagnosed or treated for:

8. High blood pressure, high cholesterol, abnormal electrocardiogram, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?	☐	☐

	Yes	No
9. Hepatitis, ulcer, internal bleeding, colitis, acid reflux, GERD, or any other disease or disorder of the stomach, gall bladder, esophagus, liver, pancreas, spleen, intestines, colon, or rectum?	☐	☐
10. A disorder of your blood or immune system including anemia, blood clots, bleeding, immune deficiency, leukemia, or lymphoma (excluding HIV)?	☐	☐
11. Cancer, tumor, melanoma, or any other malignant disorder?	☐	☐
12. Diabetes or high blood sugar or any other disease or disorder of the pituitary, thyroid, or endocrine glands?	☐	☐
13. Albumin, protein, blood or sugar in the urine or any other disease or disorder of the kidney or bladder?	☐	☐
14. Cyst, polyp, lump, or other growth, or any disease or disorder of the skin or lymph nodes?	☐	☐
15. Any disease or disorder of the uterus, cervix, ovaries, or breasts?	☐	☐
16. Any disease or disorder of the prostate or reproductive system?	☐	☐
17. Any sexually transmitted disorders or diseases?	☐	☐
18. Complications of pregnancy or infertility? If now pregnant, what is the expected date of delivery? _____	☐	☐
19. Asthma, shortness of breath, chronic cough or hoarseness, bronchitis, emphysema, COPD (chronic obstructive pulmonary disease), sarcoidosis, pneumonia, TB (tuberculosis), sleep apnea, or any other disorder of the respiratory system?	☐	☐
20. A disorder of the brain, spinal cord, or nervous system including chronic headaches, convulsions or loss of consciousness, seizures, tremors, paralysis, fainting, stroke, MS (multiple sclerosis), or TIA (transient ischemic attack)?	☐	☐
21. Depression, anxiety, psychosis, suicidal thoughts or attempts of suicide, anorexia or bulimia, obsessive compulsive disorder, bipolar disorder, or other mental, nervous or emotional disorder?	☐	☐
22. Arthritis or disorder of the bones, skin or muscles?	☐	☐
23. Any disease or disorder of the eyes, ears, nose or throat?	☐	☐
24. Unless previously stated on this application, have you:		
a. Been treated by a member of the medical profession or at a medical facility?	☐	☐
b. Had an electrocardiogram, x-ray, blood test, or other diagnostic test, excluding an HIV test?	☐	☐
c. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?	☐	☐
d. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing, excluding HIV testing, that has not yet been completed?	☐	☐
e. Been referred to any other member of the medical profession or medical facility?	☐	☐
25. a. Have you used amphetamines, barbiturates, cocaine, heroin, crack, marijuana, LSD, PCP, or other illegal, restricted or controlled substances, except as prescribed by a licensed physician?	☐	☐
b. Have you been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs?	☐	☐
26. Have you:		
a. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages?	☐	☐
b. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems?	☐	☐
c. Attended or joined any organization due to alcohol or related problems?	☐	☐
27. Have you taken, or are you currently taking, or have you been advised to take any prescribed medication other than contraceptives? if Yes, give details in Additional Information section.	☐	☐

	Yes	No
28. Have you been diagnosed or received treatment from a member of the medical profession for ARC (AIDS-Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) ?	☐	☐
29. Have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disease or disorder not previously stated on this application? If Yes, give details in Additional Information section.	☐	☐
30. Have you used tobacco or nicotine products in any form? If Yes, give details in Additional Information section.	☐	☐
31. Have you been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?	☐	☐
32. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in, certain activities such as hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving?) If Yes, complete appropriate questionnaire.	☐	☐
33. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft? If Yes, complete Aviation Questionnaire.	☐	☐
34. Do you intend to travel outside the U.S. or Canada, or change your country of residence in the next 12 months? If Yes, list countries, cities, duration and purpose of travel in Additional Information section.	☐	☐
35. Are there any plans to sell or permanently assign the policy to a life settlement provider or an investor? If Yes, provide details in Additional Information section.	☐	☐

ADDITIONAL INFORMATION - Details regarding any "Yes" answers.

For questions 24, 26, 27 and 29 indicate the medical condition, date of onset and recovery, name/address of physician, clinic or hospital. If children are covered, list names of children born or adopted since date policy was issued.

Question No.	Details

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any physician, medical professional, hospital, clinic or medical care facility; pharmacy benefit manager, prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB), to provide the Company and its legal representatives or affiliated insurers, all information they have pertaining to: medical consultations; treatments; hospitalizations for physical and/or mental conditions, use of drugs or alcohol; drug prescriptions; or any other information pertaining to me. This information does not apply to records protected under 42 USC 290dd-2. Other information could include items such as: other insurance information; personal finances; habits; hazardous avocations; motor vehicle records; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine my eligibility for insurance. I authorize that any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I understand that this consent may be revoked at any time by sending a written request to the Company, Attn: Director of Underwriting, William Penn Life Insurance Company of New York, 3275 Bennett Creek Avenue, Frederick, Maryland 21704.

The consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company to obtain an investigative consumer report on me. I understand that I may request to be interviewed for the report and receive, upon written request, a copy of such report.

If an investigative consumer report is prepared, I elect to be interviewed: ☐ Yes ☐ No

Federal Fair Credit Reporting Notice

As part of our underwriting, we may ask that an investigative consumer report be prepared. An independent source known as a consumer reporting agency will prepare the report. The report will typically include information as to your character, general reputation, mode of living, and personal characteristics. The agency may conduct personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted in order to get this information. If you write to us within a reasonable time after you receive this Notice, we will tell you whether or not a report was requested. If a report was requested, we will tell you the name, address, and telephone number of the agency to whom the request was made. Upon request, the agency will furnish information as to the nature and scope of its investigation. If you would like to inspect and to receive a copy of the report, you may do so by contacting the agency directly.

MIB (Medical Information Bureau) Pre-Notice Disclosure

Information regarding your insurability will be treated as confidential. William Penn Life Insurance Company of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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, MIB, upon request, will supply each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

William Penn Life Insurance Company of New York, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

DECLARATION

I/we the undersigned declare that the statements and answers contained on this Application for Reinstatement and any supplements thereto, are true to the best of my knowledge and belief and are made to induce the Company to reinstate the above numbered policy. I understand that this policy has lapsed for non-payment of premium and that this policy will not be in force until the Company has approved this application and the full amount of premium due is paid while the insured is living and actually in the state of health and insurability represented on the Application for Reinstatement and any supplements thereto. I agree to notify the Company of any changes in the statements or answers that occur prior to the Company's receipt of the premium due if the application for reinstatement is approved and that no insurance will be in effect if there has been a change in the insurability of the insured since the date of this application. I understand and agree that the statements and answers in this application, which include any supplemental forms, will become part of the insurance policy that is reinstated as a result of this application. I agree that the reinstatement of this policy shall be contestable at any time within two years from the effective date of the reinstatement.

_____ Signed at _____ on _____/_____/_____
Signature of Proposed Insured City/State

_____ Signed at _____ on _____/_____/_____
Signature of Owner (if other than Proposed Insured) City/State
If Owner is a firm or corporation, include officers' title with signature

_____
Print Owner/Officer Name and Title (if applicable)

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Print Name of Proposed Insured / Patient

Date of Birth ____/____/____

Print Name of Person or Organization Providing Information

AUTHORIZATION

I authorize any physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, Pharmacy Benefit Manager, treatment facility, insurer, insurance support organization, service provider, Kaiser Permanente, financial institution, consumer credit reporting agency, certified public accountants and tax preparers, educational institution, Federal, State, or Local Governmental Agency, including the Social Security Administration, Veterans Administration, or Workers Compensation Board, an authorized medical officer of a United States Government facility, law enforcement agencies, state and local tax agencies, or other medical or medically related facility, specifically including those persons/organizations listed above, to give or disclose my entire medical record and any other protected health information, or other personal, private, or privileged information concerning me for the past 10 years to **William Penn Life Insurance Company of New York**, its agents, employees, vendors or representatives. Any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. 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 except psychotherapy notes, and the use of alcohol, drugs, and tobacco; and any genetic information or genetic testing results. This information does not apply to records protected under 42 USC 290dd-2.

My Information is to be disclosed under this authorization so that **William Penn Life Insurance Company of New York** may: 1) underwrite my application for coverage, make eligibility, risk rating, and policy issuance 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 **William Penn Life Insurance Company of New York**.

I understand and acknowledge that any agreements I have made to restrict My Information, including protected health information, do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider, or other entity to release and disclose My Information, including my entire medical record without restriction.

This authorization shall be valid for two (2) years after the date on which it is signed by me, and a copy of this authorization is as valid as the original.

I understand that I have the right to refuse to sign or to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 3275 Bennett Creek Avenue, Frederick, Maryland 21704, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that the Company has taken action in reliance on this Authorization or 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 redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign, alter, or revoke this Authorization the Company may not be able to process my application and it may be a basis for denying my request for coverage, or if coverage has been issued may not be able to make any benefit payments. I understand and acknowledge that I will receive or have received a copy of this authorization.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Signature of Proposed Insured / Patient

Date (required)

Social Security Number of Proposed Insured

Agent or Witness Signature