Mountain Life Insurance Company
Reinstatement Application

DATE:________________________ **INSURED'S NAME:____**

POLICY NUMBER:__________________ **DATE PREMIUM DUE:____________________________________**

Since the date of the original application for this policy or within the past 5 years, if less, have you:

1. Changed occupations? Yes______ No______

2. Been declined, rated, postponed for insurance or reinstatement, or had a policy issued other than applied for, or had a policy canceled or renewal refused? Yes______ No_______

3. Applied for, received or been refused a pension, disability or medical benefits? Yes_____ No_______

4. Have you or do you intend to pilot an aircraft, scuba dive, race motor vehicles, skydive, or participate in any other similar activity or sport? Yes______ No_______

5. Have you consulted a doctor or other health care provider or been hospitalized? Yes_______ No______

6. Been treated for or advised by a licensed physician that you have any of the following: disease of the heart, blood, lungs, liver, or kidneys; AIDS or AIDS related illness, any mental, nervous, circulatory, digestive, or immune disorder; high blood pressure; cancer or tumor; diabetes; drug or alcohol abuse? Yes______ No_____

If you answered **Yes** to any question above, please provide details (indicate dates, reasons, names and phone numbers of doctors).

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. (In Arkansas) Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AUTHORIZATION TO OBTAIN INFORMATION:
I hereby authorize any individual, physician, medical practitioner, hospital, clinic, other medical related facility, the Medical Information Bureau, insurance company, consumer reporting agency, rehabilitative assessment agency or government authority to furnish Mountain Life Insurance Company, its reinsurer(s) or their representatives any information related to health, medical history, diagnosis, and treatment (including copies of records) concerning the above referenced individual. These records should include any treatment regarding alcoholism, drug abuse; AIDS, HIV testing, AIDS related illness and psychiatric care or any physical or mental condition and/or treatment rendered. I understand that Mountain Life Insurance Company or its reinsurer(s) will use this information to determine eligibility for insurance. I agree this Authorization is valid for two and one half years from the date signed. I know that I have a right to receive a copy of this Authorization upon request. I agree that a photographic copy of this Authorization is as valid as the original. I acknowledge receipt of the Notice of Information Practices, including the notices explaining my right under the Fair Credit Reporting Act as it pertains to investigative consumer reports and the Medical Information Bureau. The statements and answers in this application are true and complete to the best of my knowledge and belief. It is agreed that no insurance shall take effect unless and until the Company approves this application at its home office. **I have read and agree to all the terms and conditions above and the "Notice of Information Practices" on the reverse side of this form.**

____________________________________ ____
Signature of Insured **Date**

____________________________________ ____
Signature of Witness **Date**

MOUNTAIN LIFE INSURANCE COMPANY
P.O. Box 240
Alcoa, Tennessee 37701-0240
800-888-6542

Medical Records Release Authorization

Completion of this Authorization is required in order to consider your application for our insurance or to make a determination of eligibility for benefits on your claim.

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to Mountain Life Insurance Company for the purpose of:

Circle the purpose(s)

1) **Determining eligibility for insurance;**

2) **Determining benefits payable on a disability claim;**

3) **Determining benefits payable on a life claim.**

I understand and agree that Mountain Life Insurance Company may disclose my medical records and the information contained in those records to third parties, such as insurance companies, or to the representatives of such third parties (including reinsurers and information agencies) for the purpose(s) stated above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Mountain Life Insurance Company has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to:

Mountain Life Insurance Company
P.O. Box 240
Alcoa, Tennessee 37701-0240

This Authorization will expire on _________________________, or if no date is filled in, twelve (12) months after the date the Authorization is signed.

A photocopy of the Authorization will be as valid as the original for the authorized purpose(s).

______________________________	______________________________
Signature of Individual Whose Information is to be Disclosed or Authorized Representative	**Date of Birth**
______________________________	______________________________
Print Name of Individual	**Date**