INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT (herein called "Company")
930 E. 2nd Street, Suite 100, Edmond, Oklahoma 730στ ♦ 1-800-821-5434

INSURANCE REINSTATEMENT APPLICATION

Policy/Certificate Number requested to be reinstated: _____

List all persons covered under this Policy/Certificate (print full names):

	Last Name	First Name	Relationship	Date of Birth
Primary Insured				
Joint Insured				

With respect to *each* of the persons insured under the Policy/Certificate:	Primary Insured		Joint Insured	
	Yes	No	Yes	No
1. Are you or anyone else insured currently disabled or suffering from any illness, injury or disease?	☐	☐	☐	☐
2. Have you or anyone else insured had any illness or personal injury of any kind, or have consulted, been operated on or treated by any physician or other practitioner since the original effective date of the Policy/Certificate?	☐	☐	☐	☐
3. Since the effective date of the Policy/Certificate, have you had an application or reinstatement request for life or accident and health insurance postponed or limited, or have you been asked to pay a higher premium?	☐	☐	☐	☐

Give details of all above "Yes" answers including name of person, all dates of treatment, names and addresses of attending physicians and hospitals, type of treatment.

The undersigned hereby certifies that the statements and answers contained in this Application are complete and true to the best of his/her knowledge. I (we) further agree that all statements and answers in this Application shall be taken as the basis of reinstatement.

It is further agreed that the reinstatement of the Policy/Certificate shall not become effective until:
1) This Application is approved by the Company;
2) Reinstatement premium is paid and received by the Company; and
3) Any outstanding indebtedness due the Company is either repaid or reinstated.

If this Policy/Certificate is reinstated, the Company will not contest it with respect to statements made in this Application that materially relates to insurability after the Policy/Certificate has been in force for two years from the date of reinstatement and during the lifetime of the Insured.

Insurance Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison, and denial of insurance benefits, depending on state law.

Signed at _____ this _____ day of _____, 20_____

_____ _____
Primary Insured's Signature Other Insured's Signature

_____
Owner's Signature (if other than insured)

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930 E. 2nd Street, Suite 100, Edmond, Oklahoma 73034 Phone: 1-800-821-5434
Mailing Address: P.O. Box 30685, Edmond, OK 73003-0012 Fax: 405-285-0836

Authorization for Release of Information – Life Insurance Underwriting

Primary Insured/Applicant (please print)		Joint Insured/Applicant (please print)	
Date of Birth	Social Security # (last 4 digits) XXX-XX-_____	Date of Birth	Social Security # (last 4 digits) XXX-XX-_____

I (the undersigned) authorize any physician or medical practitioner, any hospital, clinic, other health care facility, pharmacy, pharmacy benefit manager, employer or benefit plan administrator, any insurance or reinsurance company, any consumer reporting agency or the Medical Information Bureau (MIB) to release information from the records of:

Information to be released: Any and all individually identifiable health information including:

- Information about the diagnosis, treatment or prognosis of my medical condition (including referral documents from other facilities); and
- Prescription drug records and related information maintained by physicians, pharmacy benefit managers and other sources.

Information is to be released to **Underwriting Department, Individual Assurance Company (IAC) at 930 E. 2nd Street, Suite 100, Edmond, Oklahoma 73034** and its reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations.

I understand that the purpose of disclosing this information is to evaluate my application for insurance. The Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:

- To reinsurance companies, the MIB or providers of a business or legal service concerned with my application; and
- As otherwise may be required by law or may be further authorized by me.

I authorize Individual Assurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I further understand that refusal to sign this Authorization may result in denial of eligibility for this insurance coverage.

I understand the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law, however, the Company contractually requires the recipient to protect the information.

I understand that I may revoke this Authorization in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my coverage with the Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

A photocopy of this Authorization is to be considered as valid as the original. I understand that I am entitled to receive a copy of this Authorization. I acknowledge that I have received the attached Consumer Protection Notices.

Signature of Primary Insured/Applicant: _____ Date:_____

Signature of Joint Insured/Applicant:_____ Date:_____

CONSUMER PROTECTION NOTICES FOR THE APPLICANT

Investigative Consumer Report Notice – In connection with your application for insurance, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may make a written request to be interviewed in connection with the preparation of this report. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. Either of these written requests should be directed to the Underwriting Department, Individual Assurance Company, P.O. Box 30685, Edmond, OK 73003.

MIB, Inc. Notice – Information regarding your insurability will be treated as confidential. We, or our reinsurers, may make a brief report 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 such 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 the MIB at 866.692.6901 (TTY 866.346.3642 for hearing impaired). If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

We, or our reinsurers, may also release information in our 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.

Detach these notices and keep for your records