

1. I am requesting full reinstatement of Policy Number _____, dated _____, on my life. I enclose due premiums of \$ _____. This policy ended because the premium due on _____ (date) was not paid.
2. Insured Name (first, middle, last) _____

| | | |
|----------------------|-------------|----------------|
| | Birth date | ID No. |
| | Height | Weight |
| Street address _____ | state _____ | zip code _____ |
| city _____ | | Phone _____ |
| | | Email _____ |
3. Since the date of your last application for insurance to CNA International Life Company, have you applied for any life, accident or health insurance which has not been granted exactly as applied for in kind, amount or rate? (If yes, give full details in # 11) Yes No
4. Since the date of your last application for insurance to CNA International Life Company, has any insurance issued to you been cancelled or its renewal or reinstatement refused? (If yes, give full details in # 11) Yes No
5. Since the date of your last application for insurance to CNA International Life Company, have you consulted any physicians or visited a clinic or hospital as a patient, or do you plan to within the next 30 days? Yes No
6. Have you ever received advice or treatment for:
 (If yes, check the items that pertain and give full details in # 11) stroke ; mental or nervous disorder ; lung or respiratory disorder ; high blood pressure ; chest pain ; disease of the heart ; kidney disease ; cancer or tumor of any kind ; diabetes ; liver ; brain ; shortness of breath ; use of alcohol or drugs ? Yes No
7. Do you now, or do you intend to engage in sky or scuba diving, hang gliding, rock climbing, or any form of motorized racing? (If yes, Hazardous Sports Questionnaire is required). Yes No
8. Do you now, or do you intend to, fly as a pilot, student pilot or crew member? (If yes, Aviation Questionnaire is required). Yes No
9. Have you used tobacco or nicotine products since the date of your last application to CNA International Life Company? Yes No
10. What is your present occupation? _____
11. Details of 'yes' answers. Give dates, diagnosis, treatment, and names and addresses of attending physicians and medical facilities. _____

Authorization To Obtain Information

The Proposed Insured authorizes any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, including psychiatric conditions, drug or alcohol abuse, and any other medical or non-medical information about the Proposed Insured or the Proposed Insured's health to give to CNA International Life Company or its legal representatives, any and all such information.

The Proposed Insured authorizes all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

The Proposed Insured understands the information obtained will be used by CNA International Life Company to determine eligibility for insurance. Any information obtained will not be released by CNA International Life Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with the Proposed Insured's application, or as may be otherwise lawfully required or as the Proposed Insured may further authorize. The Proposed Insured understands that they may request to receive a copy of this Authorization.

The Proposed Insured agrees that a photographic copy of this Authorization shall be as valid as the original.

The Proposed Insured acknowledges having received and read the Notice to the Proposed Insured and the Medical Information Bureau Notice. The Proposed Insured agrees that this Authorization shall remain valid for two years from its date.

The Proposed Insured and the Applicant, if other than the Proposed Insured, agree(s) that: (1) all statements and answers in this application are complete, true and correctly recorded to the best of their knowledge and belief; (2) if this application is accepted by the Company, the policy applied for, this application, the original application, and any attachments will constitute the entire insurance contract; (3) insurance will not take effect until the application is approved and accepted by the Company, and the premium required to reinstate the policy has been paid in full.

The Proposed Insured understands: (1) that if the policy was in-force less than two years prior to lapse, the Incontestability and Suicide provisions of the policy will still apply for any remaining portion of the 2 year period beginning on the effective date of reinstatement; and (2) any reinstatement will be incontestable, except for non-payment of premium, only after such reinstatement has been in force during the lifetime of the Insured for 2 years from the effective date of reinstatement.

The Proposed Insured understands that: (1) a policy that has been lapsed for more than three (3) years cannot be reinstated; (2) we will not approve this application for reinstatement of the policy unless all due premiums, including interest, are received; (3) money received with this application will be held pending approval of this application; (4) CNA International Life Company reserves the right to obtain additional information; (5) no insurance is in force until this application is approved.

Under the penalties of perjury; the Proposed Insured and the Applicant, if other than the Proposed Insured, certify (ies) that the Identification number(s) provided herein is/are correct.

I elect to be interviewed if an investigative consumer report is prepared in connection with this application. Please contact me during the hours of _____ and _____. My telephone number is _____.

Signed at _____ this _____ day of _____
city state month year

X
 Proposed Insured (if signing on behalf of Proposed Insured, specify relationship/authority)

X
 Agent

X
 Owner (if other than the Insured)

Date (month, day, year)

Notice To Proposed Insured(s)

Detach – leave with applicant

In order to properly underwrite and administer your insurance coverage we must collect certain necessary and helpful information concerning your insurability. You are our most important source of information, but we must also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

We may obtain an investigative consumer report whereby information as to your character, general reputation and personal characteristics are secured through personal interviews with your friends, neighbors and others with whom you are acquainted.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see (and copy if you wish), items of personal information about you which appear in our files, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment, or deletion of information you believe to be inaccurate.

If you have further questions or desire additional information about the items discussed above, please write to us at CNA International Life at P.O. Box 305153, Nashville, TN 37230-5153, USA

Thank you for your application for insurance. (Please see Notice Regarding Medical Information Bureau.)

Notice Regarding Medical Information Bureau

Please read carefully

Information regarding your insurability will be treated as confidential. CNA International Life Company or their reinsurer(s) may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

CNA International Life Company or their reinsurer(s) may also make information in its file available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, MA 02112, USA.

PREAUTHORIZED PAYMENT REQUEST

I agree to the following conditions:

1. The bank account submitted below must be located in the United States and denominated in U.S. \$.
2. This authorization is revocable by the undersigned upon receipt by the Company of written revocation.
3. If any such draw is dishonored, the premium for which the draw is made shall be considered in default.

I am paying other premiums to you in this manner: Policy Nos. _____

and desire to have one draw each month for all premiums on the _____.

Signature (must be same as on file at bank)

Joint account signature

Name of depositor (as it appears on bank records; print)

Request and Authority to Honor Preauthorized Payments

(Attach copy of void check)

drawn by and payable to: CNA International Life Company

To: _____ (Name and address of bank and branch, if any) _____ Date

Name of depositor _____ (as it appears on bank records) Checking account number _____

As a convenience to me, I hereby request and authorize the Bank to pay and charge to my account electronic debits, checks, or drafts, drawn on my account by and payable to the order of the company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank rights in respect to each such draw shall be the same as if it were a check drawn on the Bank and signed personally by me. This authority is to remain in effect in honoring any such draw.

I further agree that if any such draw be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever even if such dishonor results in the forfeiture of insurance.

Signature (must be same as on file at bank)

Joint account signature

Name of depositor (as it appears on bank records; print)

So that you may comply with your depositor's request, CNA International Life Company Insurance Company agrees:

1. To indemnify the Bank and hold the Bank harmless from any loss the Bank may suffer as a consequence of the Bank actions resulting from or in connection with the execution and issuance of any electronic debit, check or draft, whether or not genuine, purporting to be executed and received by the Bank in the regular course of business for the purpose of payment to this Company including any costs or expenses reasonably incurred in connection therein.
2. In the event that any such electronic debit, check or draft is dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify the Bank for any loss through dishonor which results in a forfeiture of the insurance.
3. To defend at our own cost and expense any action which may be brought by any depositor or any other person because of the Bank's actions taken pursuant to this request, or in any manner arising due to the Bank's participation in this plan of premium collection.

To:

L. Susan McGary Secretary

The above is an authorization from your depositor to accept electronic debits, checks or drafts drawn by and payable to the CNA International Life Company. Your depositor has purchased insurance from our company and wishes to arrange for payment of monthly premiums in this manner.