



**COLORADO BANKERS LIFE  
INSURANCE COMPANY**  
5990 Greenwood Plaza Blvd  
Greenwood Village, CO 80111  
www.cblnet.com

DO NOT RETURN THIS VIA FAX  
WE MUST HAVE THE ORIGINAL  
PLEASE RETURN VIA THE MAIL

## Application For Reinstatement

### Accident Only

(payment must accompany this form)

|               |               |              |            |
|---------------|---------------|--------------|------------|
| Policy Number | Participant # | Paid-To-Date | Amount Due |
|               |               |              |            |

Insured's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 City/State/ZIP: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Telephone Number: Home: \_\_\_\_\_ Name of Employer: \_\_\_\_\_  
 Work: \_\_\_\_\_ Exact Job Duties: \_\_\_\_\_  
 Beneficiary: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please furnish details to all "Yes" answers and your personal physician's name and address even if you answer "No" to all questions.

- |                          |                          |   |
|--------------------------|--------------------------|---|
| Yes                      | No                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you been hospitalized for more than 5 days or been absent from work due to an accident or sickness for more than 5 consecutive work days during the past 12 months? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you been treated for injuries suffered on or off the job within the past 12 months?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Are you currently under the care of a physician?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you have residual problems as a result of injuries that occurred during the past 12 months?   |

| Question # | Details of "Yes" answers<br>Please include dates, duration attending physician's or hospital's name, address, and phone number | Provide personal physician's name and address |
|------------|--|---|
|            |  |   |
|            |  |   |
|            |  |   |
|            |  |   |

To the best of my knowledge and belief, all of my statements and answers are true and complete. I agree that reinstatement of the policy as granted by Colorado Bankers Life Insurance Company upon the application, shall be contestable for fraud or misrepresentation of any material facts stated herein or in connection herewith for two years from the date of reinstatement that this reinstatement application shall become part of the contract of insurance. I understand that my coverage is not to be considered reinstated until this application has been approved by the Company during my lifetime and past due premium has been paid. Payment of the past due premium is not binding upon the Company until this application is approved.

I hereby authorize any physician, medical practitioner, hospital, clinic, Health Maintenance Organization, including Mayo, Kaiser Foundation, Veterans Administration, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institute, or person that has any records or knowledge of me or my family, or our health, medical history or physical condition, to give Colorado Bankers Life Insurance Company or its reinsurers any such information including psychiatric histories and testify as to such information.

This authorization is valid for thirty (30) months after the date it was signed. A photo static copy of this authorization will be as valid as the original.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured