



**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
Preferred Golden Protector
(payment must accompany this form)**

Policy Number	Participant #	Paid-To-Date	Amount Due
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Insured's Name: _____ **Social Security Number:** _____
Street Address: _____ **Date Of Birth:** _____ **Age:** _____
City/State/ZIP: _____ **Height:** _____ **Weight:** _____

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. Is the proposed insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care, waiting for organ transplant, or confined to a wheelchair? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has the proposed insured ever had or been diagnosed or treated for Alzheimer's Disease or Dementia? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has the proposed insured ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. In the past 5 years, has the proposed insured had or been treated for: internal cancer, malignant melanoma or leukemia? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. In the past 5 years, has the proposed insured had, been treated for, or taken medication for: <ul style="list-style-type: none"> a. Heart surgery, heart attack, stroke, aneurysm or angina (chest pain)? b. A drug or alcohol dependency/habit, treatment for alcoholism or drug addiction, or used oxygen to assist in breathing? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. In the past 5 years, has the proposed insured had or, been treated for, or taken medication for: <ul style="list-style-type: none"> a. Emphysema, chronic lung disease (COPD), or Parkinson's disease? b. Kidney disease, kidney failure, kidney dialysis, cirrhosis or other liver disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. In the past 5 years, has the proposed insured had or, been treated for, or taken medication for: <ul style="list-style-type: none"> a. Brain tumor, pacemaker, congestive heart failure, or any other heart or circulatory disorder? b. Both high blood pressure and insulin dependant diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has the proposed insured used tobacco products in the past 12 months? |

Question #	Details of "Yes" answers 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 _____