



**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
Modified Whole Life/Ten Year Term
(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:** _____
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

1. During the past ten years have you, or any person to be covered by the policy applied for, been told you had or had been treated for:
- a. Cancer, Heart Disease or High Blood Pressure?
 - b. Diabetes or Disease of the Liver or Kidneys?
 - c. Been hospitalized for Nervous or Mental Disorder?
 - d. Alcoholism, Narcotic Addiction, Drug Habituation?
 - e. Immune Deficiency or any other Blood Disorder?
2. Have you had medical or surgical advice or treatment or been confined in a hospital during the past 5 years other than stated above?

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 _____