Phone: (512) 837-7100 ext: 3222 • Email: PHS@citizensinc.com

APPLICATION FOR REINSTATEMENT - CRITICAL ILLNESS

1.APPLICANT

Policy #	Insured(s)	Owner (If other than insured)	Date
Reason for Reinstatement:	CURRENT ADDRESS ➔		
CITIZENSHIP/TAX RESIDENCY➔	Country of Citizenship	Country of Tax Residence	Tax ID Number
COMPLETE THIS ONLY IF YOU HAVE DUAL CITIZENSHIP/RESIDENCE ➔	Country of Citizenship	Country of Tax Residence	Tax ID Number
Instructions: Complete this Application for Reinstatement and answer all questions below. Date and sign and return the form to PHS@citizensinc.com			
2. CERTIFICATE OF U.S. CITIZENSHIP OR RESIDENCY FOR TAX PURPOSES. Please check A or B and complete as applicable.			
PROPOSED INSURED:			
A. □ I am a U.S. citizen and/or resident for tax purposes (green card or green card holder under proof of substantial presence). My U.S. numbers are listed below: SSN: Tax Identification Number (if different from SSN):		B. □ I am NOT a U.S. citizen and/or resident for tax purposes. The information I have provided above regarding my country of tax residence and taxpayer reference umber (if available) is correct.	
OWNER (If other than insured)			
A. □ I am a U.S. citizen and/or resident for tax purposes (green card or green card holder under proof of substantial presence). My U.S. numbers are listed below: SSN: Tax Identification Number (if different from SSN):		B. □ I am NOT a U.S. citizen and/or resident for tax purposes. The information I have provided above regarding my country of tax residence and taxpayer reference umber (if available) is correct.	

3. STATEMENT OF HEALTH

1. Have you or the person applying for coverage ever received an organ transplant or been advised of the need for an organ transplant or tested positive for human immunodeficiency virus (HIV) or its antibodies, or been diagnosed by a medical professional as having acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC)? □Yes □No

2.Within the last two (2) years, have You or the person applying for coverage been advised to undergo treatment or testing, or had tests performed whose results are pending, were not received, were abnormal, or were inconclusive, so that a medical professional has not ruled out cancer? □Yes □No

3.Within the last five (5) years, have you or the person applying for coverage been treated for or diagnosed with cancer or any malignant disease, including: carcinoma, sarcoma, Hodgkin's disease, leukemia, lymphoma or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma. □Yes □No

4.Within the last five (5) years, have You or the person applying for coverage been diagnosed with a medical treatment, been advised to undergo medical treatment, been prescribed medication, or consulted a medical professional for any of the following conditions?

A. Heart attack, atrial fibrillation, angina pectoris, coronary artery disease, cardiac or circulatory surgery (excluding maintenance of a previously installed pacemaker), congestive heart failure, high blood pressure (causing you to now take 3 or more medications for treatment), or cardiomyopathy □Yes □No

B. Stroke or transient ischemic attack (TIA) □Yes □No

C. Complications of diabetes or insulin-dependent diabetes (excluding pregnancy) □Yes □No

D. Any liver disorder, including cirrhosis or hepatitis, kidney disease or disorder (excluding kidney stones) or kidney disease requiring dialysis, or organ transplantation □Yes □No

E. Emphysema or chronic obstructive pulmonary disease (COPD) □Yes □No

F. Amyotrophic lateral sclerosis (Lou Gehrig's disease), multiple sclerosis (MS), muscular dystrophy (MD), systemic lupus or cystic fibrosis. □Yes □No

G. Any disorder of the central nervous system, Parkinson's disease, Alzheimer's disease, dementia, senility or organic brain syndrome □Yes □No

5. Within the last five (5) years, have you or anyone applying for coverage sought counseling or treatment for alcohol abuse, been arrested for driving under the influence of alcohol or while intoxicated, or been arrested for or used illegal drugs or narcotics? □Yes □No

6. Weight and height (Only applies to applicant and spouse/partner if insured. If pregnant, please indicate weight before pregnancy):

Applicant:

Height(ft/in): _____ Weight(lbs.): _____

Spouse or partner:

Height(ft/in): _____ Weight(lbs.): _____

For office use only:
BMI of the Applicant *BMI of the Spouse or partner*

If you answered "Yes" to any of the questions in items 1, 2, 3, 3, 4, or 5 provide additional information if necessary.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

I hereby declare that the statements and answers contained above are full, complete and true to the best of my knowledge and belief and I acknowledge that this application with any other declarations of insurability submitted to the Company shall be deemed an amendment to the original application and shall form a part of the policy and constitute a sole and complete contract of insurance. EACH APPLICANT UNDERTAKES to promptly inform CICA Life A.I. and provide, to the best of his/her knowledge, an updated response to the Certification of United States Citizenship or Residency within 30 days of any change in circumstances that would cause the information contained in such certification to be inaccurate or incomplete. WHERE LEGALLY REQUIRED TO DO SO, EACH APPLICANT HEREBY CONSENTS CICA Life A.I. to share this information with the appropriate tax reporting authorities. EACH APPLICANT ACKNOWLEDGES that it is a crime to make a self-certification that is materially false. It is understood and agreed that the reinstatement of the policy is based upon the statements contained in this application and shall be disputable for falsity as to any material fact stated herein, or in connection herewith, for two years from the date of reinstatement; provided, however, that if the period of incontestability provided in the original policy has not expired, the Company does not waive its rights under the policy. If reinstatement is not approved, any sums paid hereunder shall be refunded and any receipts previously issued shall be void.

AUTHORIZATION

By this form (or a photostatic copy of it), I authorize: (i) any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility, insurance company, MIB, LLC ("MIB"), or other person, organization or institution that has any records or knowledge of me or my child's health (as applicable), to give to CICA Life A.I. or its reinsurers any such information and to testify as to such information, and (ii) the Company to conduct directly or indirectly one or more investigations at any time before or after any policy issuance concerning the undersigned with any sources and regarding such information as the Company deems relevant to issuance of a policy or any claims made under a policy. I further authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB or reinsurance companies or other persons or organizations performing business or legal services in connection with this application, or as may be lawfully required or as I may further authorize. I understand that such disclosures are as permitted by law.

This authorization is effective for 24 months from the date below and may be revoked in writing to the Company's policy servicing department.

Dated on _____ this _____ of _____ , 20 _____

City, State | Day | Month | Year

_____ _____

Witness Signature | Insured's Signature (or Parent if juvenile policy)

_____ _____

Witness Printed Name | Owner's Signature, if different from the Insured

RISK SELECTION

The risk assessment and risk classification process is necessary to consider your request. Information from several sources is being considered, including your own statements, the results of your physical examination (if necessary), and reports we receive from physicians or medical facilities where you have been treated. Your insurability information will be treated as confidential. However, we or our reinsurers may make a brief report to MIB Inc. (MIB), a not-for-profit membership organization of life 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 if a claim for benefits is submitted to such company, MIB will, upon request, provide such company with any information it may have on file. Upon receipt of a request from you, MIB will arrange for the release of any information in its file. Contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and request a correction. MIB's information office address is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. We or our reinsurers may also disclose your file information to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Consumer information about MIB can be obtained from their website at www.mib.com