CICA LIFE
A CITIZENS COMPANY

Telephone: (800) 880-5044●Email:PHS@citizensinc.com

APPLICATION FOR REINSTATEMENT

Policy #	Insured(s)	Owner (If other than insured)	Date:
BIRTH COUNTRY →	Birth Country of Insured	Birth Country of Owner	Reason for Lapsed:
CITIZENSHIP/TAX RESIDENCY →	Country of citizenship	Country of tax residency	Taxpayer Reference Number
ONLY COMPLETE THIS LINE IF DUAL CITIZENSHIP/RESIDENCY →	Country of citizenship	Country of tax residency	Taxpayer Reference Number
CURRENT ADDRESS →			

Instructions: Please complete this Application for Reinstatement and answer all questions below. Date, sign and send the form to PHS@citizensinc.com

1. Present occupation and duties of Insured(s)	2. Height and Weight, Weight Change, if any, and reason for weight change: Height(ft./in.): Weight (lbs.): Reason for weight change:
3. Has any insured had an application for insurance issued with an extra premium or other than as applied for: ☐Yes ☐No	4. Does any Insured have any other application for insurance pending: If so, give amounts and name of company(ies)? ☐Yes ☐No 5. Is any insured making or have made claims on any life insurance policy with this or any other insurance company? ☐Yes ☐No If **YES**, provide details.
6. Does any insured have a current aviation license? ☐ Yes ☐ No Does any insured intend to fly or has anyone flown since the date of the original application as a student pilot, pilot or crew member or with any duties aboard any aircraft while in flight (including flight to qualify for flight pay)? ☐ Yes ☐No If **YES**, complete Aviation Questionnaire.	7. Does any insured engage or intend to engage in hang gliding, auto or motorcycle racing, SCUBA or skin diving or any other hazardous sport or hobby? ☐ Yes ☐No If **YES**, provide details or complete appropriate Racing or SCUBA Questionnaire.
PROPOSED INSURED: CERTIFICATION OF U.S CITIZENSHIP OR U.S RESIDENCE FOR TAX PURPOSES. Please check A or B and complete as appropriate. ↓	
A. ϒ I am a U.S citizen and/or resident in the U.S. for tax purposes (green card holder or resident under substantial presence test). My U.S numbers are listed below: **SSN:** _____ **TIN (if different from SSN):** _____	B. ϒ I am NOT a U.S. Citizen or resident of the U.S. for tax purposes. The information that I provided above relating to my country of tax residency and tax reference number (if available) is accurate.
OWNER (if other than insured): CERTIFICATION OF U.S CITIZENSHIP OR U.S RESIDENCE FOR TAX PURPOSES. Please check A or B and complete as appropriate. ↓	
A. ϒ I am a U.S citizen and/or resident in the U.S. for tax purposes (green card holder or resident under substantial presence test). My U.S numbers are listed below: **SSN:** _____ **TIN (if different from SSN):** _____	B. ϒ I am NOT a U.S. Citizen or resident of the U.S. for tax purposes. The information that I provided above relating to my country of tax residency and tax reference number (if available) is accurate.

8. Since the date of the application has any insured been diagnosed, received treatment, consulted with a physician or health professional or has a physician or health professional scheduled or recommended treatment, surgery or any other medical procedure for any insured for any of the following conditions: ☐Yes ☐No

If **YES,** check the appropriate boxes below and provide details in the table. If additional space is needed, please attach a separate piece of paper with the information.

A. ☐ High Blood Pressure
B. ☐ High Cholesterol
C. ☐ Diabetes
D. ☐ Cancer/Tumor/Polyp
E. ☐ Depression/Anxiety
F. ☐ Anemia/Blood Disorders
G. ☐ Sleep Apnea
H. ☐ Seizures/Convulsions/Dizziness
I. ☐ Arthritis
J. ☐ Paralysis
K. ☐ Multiple Sclerosis
L. ☐ Parkinson's Disease/ALS
M. ☐ Colitis/Crohn's Disease
N. ☐ Cirrhosis
O. ☐ Hepatitis
P. ☐ Systemic Lupus (SLE)
Q. ☐ Eating Disorders
R. ☐ Psychiatric Disorder
S. ☐ Gallbladder disorder/Ulcer/Indigestion
T. ☐ Organ Failure/Transplant
U. ☐ Asthma/Bronchitis/Chronic Obstructive Pulmonary Disease/Emphysema/
V. ☐ Chest Pain/Heart Attack/Coronary Artery Disease/Heart Murmur
W. ☐ Stroke/Transient Ischemic Attack (TIA)
X. ☐ Human Immunodeficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS)

Letter from Above	Date of original diagnosis/treatment	Name and address of health care professional	Diagnosis/Treatment/Medications

9. Since the date of the application has any insured undergone, or has it been recommended that they undergo, any testing (e.g. blood, urine, x-ray, EKG/ECG or other testing), treatment or surgery for any of the following? ☐Yes ☐No

If **YES**, check the appropriate boxes below and provide details in the table. If additional space is needed, please attach a separate piece of paper with the information.

A. ☐ Heart
B. ☐ Arteries/Veins
C. ☐ Lungs/Respiratory System
D. ☐ Gastrointestinal/Digestive System
E. ☐ Liver/Pancreas
F. ☐ Kidney/Bladder/Urinary System
G. ☐ Prostate
H. ☐ Reproductive organs/System
I. ☐ Blood
J. ☐ Lymph Nodes
K. ☐ Immune System
L. ☐ Thyroid/Other Glands
M. ☐ Eyes/Ears/Nose/Throat/Skin
N. ☐ Muscles/Bones/Joints
O. ☐ Emotional/Psychological/Mental Disorder
P. ☐ Brain/Nervous System

Letter from Above	Date of original diagnosis/treatment	Name and address of health care professional	Diagnosis/Treatment/Medications

10. Has any insured used or is currently using any illegal, restricted or controlled substance except as prescribed by a physician? ☐ Yes ☐No If **YES**, provide full and complete details.	11. Has any insured been advised by a physician or health professional to seek or receive treatment for drug or alcohol use? ☐ Yes ☐No If **YES**, provide full and complete details.
12. Has any insured been given a medical discharge or been declined for military service because of physical or mental reasons? ☐Yes ☐No If **YES**, provide full and complete details.	13. Is any insured now pregnant? ☐Yes ☐No If **YES**, how many months? _____
14. In the last month, has the insured traveled outside of their home country? ☐ Yes ☐No If **YES**, provide full and complete details.	15. In the last month, has the insured had any fever or acute respiratory symptoms such as fever, cough, runny nose, difficulty breathing, sore throat, or been diagnosed with Coronavirus(COVID-19), SARS (Severe Acute Respiratory Syndrome), or MERS (Middle East Respiratory Syndrome) AND/OR within the last month, been exposed/come in contact with an individual that has or is suspected of having any of the aforementioned? ☐Yes ☐No If **YES**, provide full and complete details.

16. Has any insured ever had or been told to have or been treated for any other illness, disorder, injury, disease, disability, physical defect or symptom not mentioned above? ☐ Yes ☐No If **YES**, provide full and complete details.

17. Has any insured consulted any physician or health professional or been confined to any hospital, clinic, sanatorium or rest home not mentioned above? ☐Yes ☐ If **YES**, provide full and complete details

18. Has any insured taken or been advised to take any prescription or non-prescription medication not mentioned above? ☐Yes ☐No If **YES**, provide full and complete details.

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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 represent that the above statements and answers are full, complete and true to the best of my knowledge and belief and agree that this application with any other declarations of insurability submitted to the Company shall be considered an amendment to the original application and shall become a part of the policy and constitute a single and entire contract of insurance. EACH APPLICANT UNDERTAKES to advise CICA Life Ltd. promptly and provide, to the best of his/her knowledge and belief an updated response to the U.S Citizenship or U.S. Residence Certification within 30 days of any change in circumstances that causes any of the information contained in such certification to be inaccurate or incomplete. WHERE LEGALLY REQUIRED TO DO SO, EACH APPLICANT HEREBY CONSENT to CICA Life Ltd. sharing this information with the relevant tax information authorities. EACH APPLICANT ACKNOWLEDGES that it is an offence to make a self-certification that is false in a material manner. It is understood and agreed that reinstatement of the policy is based on statements in this application and shall be contestable, for misrepresentation of any material facts stated herein or in connection herewith, for two years from date of reinstatement; however, if the incontestable period provided in the original policy has not expired, the Company does not waive its rights thereunder. If reinstatement is not approved, any amount paid herewith will be refunded and any receipt previously issued will 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 by writing to the Company's policy service department.

Dated at _____ this _____ day of _____, 20 _____
City, State | Day | Month | Year

_____ _____
Signature of Witness | Signature of Insured (Parent if juvenile policy)

_____ _____
Printed Witness Name | Signature of Owner, if other than the Insured

RISK SELECTION

The process of evaluation and classification of risks is necessary in considering your application. Information from various sources is being considered, including your own statements, the results of your physical examination (if required) and reports we receive from doctors or medical facilities where you have been treated. Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the 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 a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. We or our reinsurers may also release information in your file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com