PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

Houston, Texas

APPLICATION FOR REINSTATEMENT OF INSURANCE

(Explain "Yes" Answers Fully)

I hereby apply for reinstatement of insurance under Policy # _____. Reinstatement is to be based upon statements made in this application together with those contained in my original application.

1. Has any person insured under this policy:
   a. Had any illnesses, consulted any physicians or been in any hospital or other institution for diagnosis, treatment or checkups within the past five years? Yes ❑ No ❑
   b. Had or been advised to have an x-ray, electrocardiogram, blood or urine test or test for any sexually transmitted disease or immune disorder? Yes ❑ No ❑
   c. Changed occupation since the date of original application? Yes ❑ No ❑
   d. Within the last two years engaged in or contemplate engaging in aviation as a pilot, parachuting, scuba diving, mountain climbing, spelunking, racing of any kind, hang gliding, rodeo events or organized athletic team play? Yes ❑ No ❑
   e. Smoked cigarettes or used any form of tobacco within the last 24 months? Yes ❑ No ❑
      If yes, do you smoke or use any form of tobacco at present? Yes ❑ No ❑
2. Is any person insured under this policy now pregnant? Yes ❑ No ❑
3. Does any person insured under this policy have hospitalization or major medical coverage in force? (To be answered only if major medical policy) Yes ❑ No ❑

If the answer to any of the above questions is "Yes", please furnish details. List name of Insured and give dates, diagnoses, durations, outcomes, and names and addresses of all attending physicians and medical facilities. If more space is needed, use a separate sheet of paper.

_____

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_____

Average earned monthly income: $ _____

I represent that the statements and answers in this application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that this policy shall not be considered reinstated until this application is approved by the company at its Home Office and all premiums necessary for reinstatement have been received. A check, money order or draft will be accepted conditionally subject to being honored when presented for payment.

I authorize any medical practitioner, medically-related facility, insurance company, the Medical Information Bureau, or other organization or person, that has any records or knowledge of persons to be covered or their health, to give Philadelphia American Life Insurance Company or its reinsurers any such information it may require to determine eligibility for insurance.

A photographic copy of this authorization shall be valid as the original.

I acknowledge receipt of the Notice of Disclosure of Information and the Notice Regarding Consumer Reports.

_____ _____ _____

Date Insured's Signature Owner's Signature (if other than Insured)

Insured's Telephone Number Home: _____ Work: _____

S-0004

PAL-0187

PLEASE NOTE: COMPLETION OF THIS FORM DOES NOT GUARANTEE REINSTATEMENT OF YOUR COVERAGE. THIS REINSTATEMENT WILL BE SUBJECT TO UNDERWRITING GUIDELINES AND APPROVAL.

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NOTICE REGARDING CONSUMER REPORTS

As a part of our normal processing procedure, a routine investigative consumer report may be made concerning the proposed insured's character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with your friends, neighbors and associates. If such a report is made, we will provide you with further information about the nature and scope of the report upon receipt of your written request.

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential. However, Philadelphia American Life Insurance Company or its reinsurers may request information from the Medical Information Bureau (MIB, Inc.), and make a brief report to it. The MIB, Inc. is a non-profit membership organization of life insurance companies operated as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, the MIB may supply that company with information it has in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it has in your file. If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Federal Fair Credit Reporting Act. The address of the MIB information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone (617) 426-3660.

The Company or its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted.