

REQUEST FOR REINSTATEMENT

KANAWHA INSURANCE COMPANY
P.O. Box 610, Lancaster, SC 29721-0610

COMPLETE IN BLACK INK

INSURED'S NAME _____ POLICY NUMBER _____

OWNER'S NAME _____ OWNER'S SOCIAL SECURITY # _____

OWNER'S ADDRESS _____ YES NO
City City Limits State County Zip Code

OWNER'S TELEPHONE NUMBER (____) _____ COMPANY IDENTIFICATION # _____

HEALTH QUESTIONS MUST BE COMPLETED

Section A: REINSTATEMENT

Reinstatement (Policy Not Required)

Section B: REINSTATEMENT BY REDATING

Reinstatement by Redate (Policy Required)

1. Date Policy: _____
2. Change Age To: _____
3. Mode Premium: _____

THE REPRESENTATIONS MADE IN SECTIONS C, D, AND E APPLY TO EACH PERSON INSURED UNDER THIS POLICY ON THE DATE OF LAPSE. SEE REVERSE SIDE FOR HEALTH AND LIFE INSURANCE.

Section C: ACCIDENT REINSTATE

Have any of the Persons Proposed for Coverage:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Lost eyesight in one or both eyes or lost any limb or portion of any limb?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Ever had or been treated for a back problem or a disorder of the spine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Had driver's license suspended, or had a DUI or DWI within the last 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |

If "YES", give name of person and full details _____

Section D: CANCER I & II REINSTATE

Have any of the Proposed Insureds ever been treated for or told by a professional he or she had Cancer, Leukemia, Hodgkin's Disease, Botulism, Diphtheria, Encephalitis, Meningitis, Murine Typhus, Trichinosis, Typhoid Fever or AIDS (Acquired Immune Deficiency Syndrome)?

Yes No If "YES", give person's name, condition diagnosed or treated and date of last treatment _____

CANCER III REINSTATE

Has any person proposed for insurance been diagnosed or treated for Cancer, Leukemia, Hodgkin's Disease, or AIDS (Acquired Immune Deficiency Syndrome)? Yes No If "YES", give person's name, condition diagnosed or treated and date of last treatment _____

SUPPLEMENTAL CANCER REINSTATE

Do any of the persons proposed for coverage now have, or ever been medically diagnosed as having, or been treated by a physician for Internal Cancer, Skin Cancer, Melanoma, Leukemia, Hodgkin's Disease, Malignant Growth, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?

Yes No If "YES", give person's name, condition diagnosed or treated and date of last treatment _____

Section E: DENTAL REINSTATE

Is anyone under this Policy:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Now receiving or in need of dental treatment for fillings, crowns, bridges, dentures or braces?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Now receiving or in need of any oral surgical procedures or any periodontal (gum disease or infection) treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Aware of any known dental or oral impairment or disease not specified above?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Give specific details for each "YES" answer: (Specify Name of Insured and Disorder)

SIGNATURES REQUIRED ON THE REVERSE SIDE FOR AGREEMENTS AND AUTHORIZATION

DETACH AND GIVE THIS PORTION TO PROPOSED INSURED

Notice To Proposed Insured

As part of our normal procedure for processing applications, we may obtain an investigative consumer report. This includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

We may telephone you to confirm information given in your application or to obtain additional information needed to process your application.

All information asked for in your application, or obtained from other sources, such as your physician, or hospitals where you have been treated, is for the sole purpose of determining your acceptability for the insurance coverage for which you have applied. All information obtained will be treated confidential. Upon written request, we will furnish you, or your physician, with the nature or source of the information.

THE REPRESENTATIONS MADE IN SECTION F APPLY TO EACH PERSON INSURED UNDER THIS POLICY ON THE DATE OF LAPSE.

Section F: HEALTH & LIFE INSURANCE

The undersigned hereby represents that:

1. Within the past five years, or the period since the date of issue of the policy, whichever is shorter, has any person:

	YES	NO
a. had any injury, disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. consulted, been treated or examined by a physician or other medical practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
c. been in a hospital, sanatorium or other institution for observation, diagnosis, operation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
d. ever had or been diagnosed as having an Immune Deficiency Disorder, AIDS or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
e. received advice or treatment for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
f. been declined, postponed, charged an extra premium, refused reinstatement, been issued a policy with an exclusion rider, or offered a policy on a basis different from that applied for?	<input type="checkbox"/>	<input type="checkbox"/>
g. engaged in any hazardous sports: flying as a pilot or crew member, organized motor racing, ballooning, hang gliding, skin, scuba or sky diving?	<input type="checkbox"/>	<input type="checkbox"/>
h. changed customary occupation?	<input type="checkbox"/>	<input type="checkbox"/>
i. had driver's license suspended or had a DUI or DWI?	<input type="checkbox"/>	<input type="checkbox"/>

2. Give full details to "YES" answers from the above statements 1a - 1i. Always indicate the name of the person, disease, injury or disorder, dates, results of treatment, names and addresses of each doctor and each hospital:

3. Change in weight: (disregarding a child's normal growth). If weight has changed, give present height and weight, amount of weight lost or gained and give reason for change:

AGREEMENTS

I have read the answers to the questions on the front and/or back side. The answers are correctly recorded, are full, complete and true and there are no exceptions to any answers recorded. These answers are for each person applying for reinstatement.

This policy cannot be reinstated until all amounts due are paid. Kanawha has no liability except to return payments made with no interest, unless all amounts due are paid. Kanawha must also approve this request. This request must be approved during the lifetime and good health of all persons to be insured under this policy.

Reinstatement can be contested under the "Incontestability" provision in the Policy. This period starts from the date of reinstatement.

AUTHORIZATION

By this form (or photocopy of it), which is valid for 30 months from the date shown below. I authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me or my child for whom insurance application is made, or my health or my child's health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law.

I also acknowledge that I have received the Notice To The Proposed Insured and the MIB Disclosure Notice which were attached to this application.

I understand the reinstated policy shall only cover losses sustained after the date of reinstatement as set out in the policy's reinstatement provision.

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

DATE	AGENT	DATE	SIGNATURE OF POLICYOWNER
SIGNATURE OF INSURED IF DIFFERENT THAN POLICYOWNER		SIGNATURE OF SPOUSE	

MIB Disclosure Notice - Detach and Give to Proposed Insured

Information regarding your insurability will be treated as confidential. Kanawha Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Kanawha Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.