KNIGHTS OF COLUMBUS

A FRATERNAL BENEFIT SOCIETY

APPLICATION FOR REINSTATEMENT

Contract No. _____ Amount Due _____

I hereby apply for reinstatement of the above Contract. For that purpose, I tender the Amount Due and state as follows:

(a) Within the last five years, no person insured under this Contract has consulted a physician except for routine physical examinations and no person insured under this Contract has been a patient in any hospital.

(b) There has been no change in any insured's occupation since the date of the initial application for this policy.

(c) No insured is engaged in aviation except as a passenger on commercial airlines.

If there are any exceptions to (a), (b), or (c), list them below:

_____

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_____

I agree that the statements contained in this Application are complete and true to the best of my knowledge and belief and that all exceptions have been fully set forth.

I agree that, if the Knights of Columbus reinstates this Contract, its Incontestability provision shall operate anew from the date of reinstatement as to statements made in this Application.

APPLICATION MUST BE DATED AND SIGNED

_____
Date

_____
Signature of Insured (if at least 18)

_____
Signature of Owner (if other than Insured or if Insured is under 18)

INSTRUCTIONS: Complete and sign both sides of this form. Mail with Amount Due to Knights of Columbus, Reinstatement Unit, P.O. Box 554, Elmsford, NY 10523.

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU, MIB, Inc. (MIB)

The MIB is a non-profit organization. It operates as an information exchange for its members. The Knights of Columbus is a member of the MIB.

We make reports to the MIB on factors affecting your insurability. We will not inform them of our decision on your applications. If you subsequently apply to another MIB member company for life or health insurance or submit a claim for benefits, the MIB will, upon request, supply that company with information in its files. The Knights of Columbus or its reinsurers may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits is submitted. None of the information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance or is passed on to any organization or Third parties.

Upon written request, the MIB will arrange disclosure of any information it may have on you in its files. If you feel the information in the MIB file is not correct, you may contact the MIB and seek a correction in accordance with procedures outlined in the Federal Fair Credit Reporting Act.

The MIB's address is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Its telephone number is: (866) 692-6901. TTY 866-346-3642 (for hearing impaired). Their email address is: infoline@mib.com.

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AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Knights of Columbus or its reinsurers any such information. Information gathered will not be used to determine sexual orientation.

I also authorize the Knights of Columbus to release any information regarding me or my health to the Medical Information Bureau, MIB, Inc.; any company to which my application is submitted for reinsurance purposes, my Knights of Columbus agents; and to other life insurance companies with whom I have policies or to whom I may apply for insurance.

This Authorization expires two years from the date shown below unless sooner revoked by writing to us at P. O. Box 1670, New Haven, Connecticut 06510-3326. Revocation of authorization must be in writing and must be signed and dated. Revocation may be a basis for denying coverage.

Failure to sign this authorization statement may impair the ability of the Knights of Columbus to process this application and may be a basis for denying this application.

A photographic copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this Authorization.

I acknowledge receiving and reading the above Notice.

Dated _____ 20_____ Signed_____
Insured (if at least 18)

Signed _____
Owner (if other than Insured or if Insured is under 18)