CICA LIFE OF AMERICA
A CITIZENS COMPANY

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Telephone: (800) 880-5044 • E-mail PHS.USA@citizensinc.com

APPLICATION FOR REINSTATEMENT

Policy Number (10-digits)	Insured(s)	Owner (If other than Insured)	Date

INSTRUCTIONS: Please complete this Application for Reinstatement, answer all questions below, and **submit a copy of your government issued I.D.** Date and sign the form and email the completed form to: **PHS.USA@citizensinc.com**

HEALTH QUESTIONS: I affirm that the answers provided below will be true and complete to the best of my knowledge and belief.

A.) Are you currently hospitalized, confined to a bed or nursing facility, residing in an assisted living facility, receiving hospice care, or do you have any physical or mental impairment for which you need or receive assistance or supervision in performing normal activities of daily living, unable to care for yourself, or terminally ill? ☐ YES ☐ NO

B.) Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ YES ☐ NO

C.) Have you been diagnosed by a member of the medical profession with more than one occurrence of any cancer, a recurrence of any cancer, metastasis of any cancer, or currently being treated for cancer (excluding basal cell or squamous cell skin cancer)? ☐ YES ☐ NO

D.) In the past 10 years, have you been medically diagnosed, for which you have not been treated by a member of the medical profession, or have not taken medication for the following: uncontrolled diabetes, uncontrolled high blood pressure, stroke/TIA, paralysis, Congestive Heart Failure, heart disease, cardiomyopathy, lung disease (including COPD (Chronic Obstructive Pulmonary Disease)/emphysema), liver cirrhosis or failure, kidney (renal) failure/insufficiency, or chronic/end-stage kidney disease (including dialysis)? ☐ YES ☐ NO

E.) Have you ever been medically diagnosed, treated by a member of the medical profession, or taken medication for mental disorder, disorder of the brain or nervous system, Systemic Lupus (SLE), Alzheimer's disease, dementia, brain disease, organic brain syndrome, Lou Gehrig's disease (ALS), Huntington's disease, Muscular Dystrophy, Cystic Fibrosis, Pulmonary Fibrosis, or Multiple Myeloma? ☐ YES ☐ NO

F.) In the past 2 years, have you been hospitalized 2 or more times, or have you been advised or recommended to have any tests, treatment, surgery, or hospitalization which has not been received or completed? ☐ YES ☐ NO

G.) Within the last 2 years, have you been treated for or been advised by a medical professional to have treatment for alcohol, drug, opioid, or controlled substance abuse, plead guilty or been convicted of a felony or misdemeanor for any reason, or attempted suicide? ☐ YES ☐ NO

H.) Within the last 5 years have you been advised to by a member of the medical profession to have an organ transplant? ☐ YES ☐ NO

Physician Name and Address: _____

Current medications, dosage(s) and usage(s): _____

ADDITIONAL REMARKS

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. I affirm that all the statements on this application are true and complete to the best of my knowledge and belief and that they shall be the basis for and a part of the reinstated policy.

I understand and agree that the Company is not bound to reinstate the above-mentioned policy and has no liability unless the policy is reinstated and premium paid (date of receipt at the Company's office shall be considered the date of payment) while the Proposed Insured's health and other conditions affecting insurability remain as described herein.

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 therein or in connection therewith, 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.

HIPAA PRIVACY AUTHORIZATION

THIS AUTHORIZATION COMPLIES WITH HIPAA PRIVACY RULE: By executing this Authorization, I authorize all health care providers, plan, or clearinghouse, insurance company, pharmacy benefit manager, Medicare or Medicaid agencies, or MIB, LLC ("MIB"), or Consumer Reporting Agency that have been involved in the care, diagnosis or treatment (including but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose medical records of the Proposed Insured (including but not limited to, patient histories, progress notes, test results, x-rays, and other diagnostic information) to CICA Life Insurance Company of America for the purpose of determining eligibility for payment of a claim or issuance of a policy.

This authorization includes information about mental illness and the use of drugs, alcohol and/or tobacco (excluding psychotherapy notes); prescription drug information, sexually transmitted disease, Human Immunodeficiency Virus (HIV infection), Acquired Immune Deficiency Syndrome (AIDS), and the diagnosis, treatment, or prognosis of any physical condition.

I understand and agree that the hospital or doctor indicated may disclose the medical records on the Proposed Insured and the information contained in those records to CICA Life Insurance Company of America for the purpose stated above.

This information will be used by CICA Life Insurance Company of America to determine eligibility for insurance and administer coverage.

I also understand that when the medical records are disclosed pursuant to this Authorization, the medical records on the Proposed Insured and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization, except to the extent that any healthcare provider or hospital or doctor indicated above has acted in reliance upon this Authorization. My revocation of this Authorization must be submitted in writing to CICA Life Insurance Company of America, P.O. Box 149151, Austin TX, 78714-9151.

AUTHORIZATION

By this form (or a photostatic copy of it), I hereby 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, my health, or my child's health (as applicable), to give to CICA Life Insurance Company of America 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 will expire six months after the date the Authorization is signed.

SIGNED AT (City and State) _____ SIGNATURE _____
Proposed Insured (parent or guardian, if minor)

DATE _____ SIGNATURE _____
Applicant/Policyowner (if different from Proposed Insured)

Printed Witness Name _____ WITNESS SIGNATURE _____

Witness