PNB Life Insurance, Inc.

☐ Back Premiums
☐ Redating

APPLICATION FOR REINSTATEMENT

Policy No.	Policyowner	Insured

HEALTH STATEMENT

Since your last medical examination, non-medical declaration or health statement made in connection with the above-numbered policy:	Insured		Payor		Please give full details of any "Yes" answer
	Yes	No	Yes	No	
1. Have you had any illness, injury, operation, treatment or medication or have you consulted or been examined or advised by any doctor?					
2. Has there been any change in your weight?					
3. Has there been any change in your health?					
4. Have you made any application for insurance/reinstatement with another insurance company which was declined, postponed or modified?					
5. Have you changed your occupation?					
6. Have you undertaken any hazardous avocation (automobile racing, scuba diving, etc.)					
7. Do you plan to work abroad soon? Where, when and in what capacity?					
FOR WOMEN ONLY 8. Are you pregnant? If so, how many months?					

I/We hereby declare that each of the above representations is true and correct and that I/we have fully stated all exceptions to each of the statements.

I/We agree that the above-numbered policy shall not be reinstated by reason of any payment made by me/us unless this application is actually approved by the Company during my/our lifetime and good health and until all other requirements for the issuance, amendment or reinstatement of said policy are fully satisfied. If this application is disapproved, I/we also agree to accept the refund of all payments made in connection herewith, without interest, and to surrender the receipts for such payments.

I/We further agree that the reinstatement of the said policy, as granted by the Company upon this application, shall be contestable at any time within two years from date of approval thereof, for fraud or misrepresentation of any material facts herein stated.

Dated at _____ this _____ day of _____ 20 _____.

_____ Printed name and signature of Witness

_____ Printed name and signature of Insured

_____ Printed name and signature of Witness

_____ Printed name and signature of Policyowner

FOR HOME OFFICE USE ONLY