Vantis Life Insurance Company
PO Box 310 Millville NJ 08332-0310
P: 1-866-826-8471 ■ www.VantisLife.com

Reinstatement Request

General Information

Full Name of Proposed Insured: _____

Address: _____

Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____ Social Security Number: _____

Policy Number: _____ Medical Number: _____

Medical Information

Name & Address of Physician(s) (If None, state None)	Reason Consulted	Dates Seen	Medication or Treatment Given (If None, state None)

1) Have you been continuously and actively at work on a full time basis (minimum 30 hours per week) at the occupation specified above for the last 90 days? ☐ Yes ☐ No (If "No", give details)

2) Have you ever been told you had, or had reason to suspect that you had, consulted with, or been treated by a doctor for any of the following: Cancer; High Blood Pressure; Ulcer; Tumor; Diabetes; Glandular Disorder; Any Brain or Nervous System Disorder; Heart Attack; Chest Pain or Heart Disorder; Any Disorder of the Kidneys, Lungs, Blood, Liver; Any Drug or Alcohol Habit; Acquired Immunodeficiency Syndrome (AIDS); or a Disease of the Immune System? ☐ Yes ☐ No If "Yes", give details

3) Have you ever used barbituates, heroin, narcotics, amphetamines, cocaine, or any drugs except prescribed by a Physician? ☐ Yes ☐ No If "Yes", give details

4) Within the last 3 years, have you engaged in or do you contemplate engaging in: skydiving, skindiving, or scubadiving; motorcycle or auto racing; hang gliding; or any other hazardous sport or hobby?
☐ Yes ☐ No If "Yes", complete the avocation questionnaire.

5) Within the last 3 years, have you flown or do you contemplate flying other than as a fare-paying passenger on a commercial airline? ☐ Yes ☐ No If "Yes", complete the aviation questionnaire.

6) Since the issuance of the above numbered policy, has the insured made an application for life insurance which was declined, postponed or accepted at extra premium?
☐ Yes ☐ No If "Yes", Company Name _____
Reason for adverse action: _____

Authorization to Release Information

I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to Vantis Life or its reinsurers, or its legal representatives. Any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person. I understand that the information released to Vantis Life or its reinsurers or its legal representatives will be used to determine my eligibility for the insurance requested. Vantis Life may re-disclose such information for that purpose to any reinsurer, and to any person or entity performing a business or legal function for the benefit of Vantis Life. This information may also be re-disclosed as otherwise specifically permitted or required by law. This authorization extends to and includes any information relating to alcohol or drug abuse, tobacco use history or mental health care. This authorization or photocopies of it will be valid for two and one half years following the date signed, unless otherwise required by law. The information released to Vantis Life will not be given, sold or transferred to any other person not mentioned above.

X	X	
Signature of Proposed Insured	Signature of Owner (if different from Proposed Insured)	Date

Vantis Life®
Insurance Company

AUTHORIZATION TO OBTAIN AND DISCLOSE PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR INSURANCE

Name of Insured: _____Date of Birth:_____

Address:_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Vantis Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (*HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information does not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Vantis Life may:

1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
2) obtain reinsurance;
3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) administer coverage; and
5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Vantis Life.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to Vantis Life Insurance Company, PO Box 310, Millville NJ 08332-0310 Attention: Underwriting Department. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or the extent that Vantis Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Vantis Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

_____

Signature of Individual Whose Information is to be Disclosed or Authorized Representative

_____ _____

Print Name of Individual or Authorized Representative Date Signed

COMPLETE IN DUPLICATE AND RETAIN A COPY FOR YOUR RECORDS