VANTIS LIFE INSURANCE COMPANY

PO Box 310 Millville NJ 08332-0310
WWW.VANTISLIFE.COM Ph: 1-866-826-8471 Fax: 1-860-298-5483

POLICYOWNER CHANGE REQUEST FOR: ☑ REINSTATEMENT ☐ RATE REDUCTION

(SELECT ONE)

INSTRUCTIONS: This application must be completed in its entirety.
Provide explanations for any "YES" answers in the Additional Explanations section on page 2.
Please fax or mail the completed form to Vantis Life at the fax/address provided above.

Policy Number(s): _____

♦ GENERAL INFORMATION ON THE PROPOSED INSURED

First Name: Middle Initial: Last Name: Gender: ☐Male ☐Female

Date of Birth (mm/dd/yyyy): Place of Birth (State/Country): Social Security #:

Does the Proposed Insured have a valid Drivers License? ☐ Yes ☐ No or ☐ No, have never been issued a license
If Yes, Provide Drivers License #: _____ State: _____ If No, Please provide details in the Additional Information Section

Is the Proposed Insured a U.S. Citizen? ☐ Yes ☐ No Is the Proposed Insured a U.S. Permanent Resident? ☐ Yes ☐ No
Does the Proposed Insured hold an active & current Green Card? ☐ Yes ☐ No, If yes, please provide Green Card #:

Home Address: (Number, Street, and Apt.#) *(No P.O. Box please)* Phone (HOME/CELL): (WORK):

City: State: Zip: Email Address:

Mailing Address if different than home (Number, Street): City: State: Zip:

Is the Proposed Insured currently employed? ☐ Yes ☐ No Occupation _____
Annual Income (If retired or unemployed provide Household Income):

Is the Proposed Insured currently disabled ☐ Yes ☐ No If Yes, please provide details in the Additional Information Section
If No, please provide reason for unemployment in Additional Information Section
Has the Proposed Insured collected disability benefits in the last two years? ☐ Yes ☐ No

♦ INSURANCE INFORMATION ON THE PROPOSED INSURED

Current Height: ___Ft. ___ Ins. Current Weight: _____ Lbs. In the last 12 months: Weight ☐ gain / ☐ loss: _____ Lbs.

1a. Full Name of Physician: _____
Address: _____
City: _____ State: _____ Zip Code: _____

1b. Date Last Consulted? _____ Reason Consulted? _____

1c. Was any treatment given or medication prescribed? (If Yes, give details.) ☐ Yes ☐ No _____

2. Is the Proposed Insured currently confined to a hospital, nursing home, psychiatric facility or currently receiving home health care/assisted living care? ☐ Yes ☐ No

- CONTINUED ON PAGE 2 -

♦ INSURANCE INFORMATION ON THE PROPOSED INSURED, CONTINUED

3. Since the issuance of the above mentioned policy, has the Proposed Insured ever been declined, postponed, or offered rated life or health insurance or been denied a reinstatement, reissue or renewal for life or health insurance? ❑ Yes ❑ No

4. In the past three years has the Proposed Insured or does the Proposed Insured intend in the next two years to:
   a. pilot an aircraft (other than scheduled commercial or corporate aviation? ❑ Yes ❑ No
   b. engage in any of the following: sky sports, underwater sports to a depth of greater than 100 feet, climbing sports greater than 5.0 difficulty, motor sport traveling at speeds (in any type vehicle) in excess of 100 miles per hour or bungee jumping, heli-skiing, hang gliding, sky diving, parachuting, base jumping? If Yes, complete Questionnaire ❑ Yes ❑ No

5. In the past ten years, has the Proposed Insured been diagnosed with or treated by a licensed member of the medical profession for any of the following:
   a. Heart Disease, Heart Attack, Chest Pains, congestive heart failure, irregular heart beat, arrhythmia, high blood pressure, open heart surgery, coronary artery bypass surgery, angioplasty or stent placement? ❑ Yes ❑ No
   b. Diabetes, stroke (CVA) or a Transient Ischemic Attack (TIA)? ❑ Yes ❑ No
   c. Depression, anxiety, suicide attempt(s) or any other mental disorder? ❑ Yes ❑ No
   d. Any disease of the central nervous system (such as dementia, Parkinson's Disease, Huntington's Disease, Multiple Sclerosis, etc.) ❑ Yes ❑ No
   e. Cancer, tumor, leukemia, blood disorder, lymphoma or melanoma (except basal cell cancer of the skin)? ❑ Yes ❑ No
   f. Chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), asthma, sleep apnea, pulmonary embolism or in the past three years had more than one episode of pneumonia or influenza? ❑ Yes ❑ No
   g. Kidney disease, renal insufficiency or any type of nephritis? ❑ Yes ❑ No
   h. Cirrhosis, hepatitis, Crohn's disease, ulcerative colitis? ❑ Yes ❑ No
   i. Drug abuse and/or treatment or alcohol abuse and/or treatment ? ❑ Yes ❑ No
   j. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ Yes ❑ No
   k. Tuberculosis, geographic fungal disease, oropharyngeal candidiasis, lymphoma, or Kaposi's sarcoma? ❑ Yes ❑ No

6. Has the Proposed Insured used tobacco products or products containing nicotine in any form (to include cigarettes, electronic cigarettes, cannabis cigarettes, snuff/chew/dip, cigars, pipes, nicotine patch and nicotine gum) in the past 5 years? ❑ Yes ❑ No
   If Yes, please provide date last used *(DD/MM/YYYY)*_____.

7. Has the Proposed Insured ever:
   a. Been treated or counseled by a licensed member of the medical profession for alcoholism, alcohol abuse or addiction? ❑ Yes ❑ No
   b. Used amphetamines, heroin, narcotics, barbiturates, cocaine, hallucinogens, cannabis or any drugs except prescribed by a physician? ❑ Yes ❑ No

8. In the last five years, has the Proposed Insured:
   a. been convicted of a felony; convicted of a misdemeanor; or is the Proposed Insured currently on parole or incarcerated in a correctional institution as a result of a conviction? ❑ Yes ❑ No
   b. been convicted of operating a vehicle while under the influence of alcohol or drugs; or does the Proposed Insured currently have a revoked or suspended license? ❑ Yes ❑ No

9. In the last three years, has the Proposed Insured plead guilty to or been convicted of three or more moving violations? ❑ Yes ❑ No

10. Has a biological parent or sibling of the Proposed Insured died or been diagnosed or treated by a licensed member of the medical profession with heart disease, stroke or cancer prior to the age of 60? ❑ Yes ❑ No

11. Have you answered "Yes" to any question above? ❑ Yes ❑ No
    If so, Please provide details to all questions answered "Yes" in the ADDITIONAL INFORMATION SECTION provided.

♦ ADDITIONAL INFORMATION SECTION (ATTACH SEPARATE SHEET IF MORE SPACE NEEDED)

♦ DISCLOSURE

I, the Owner, represent to the best of my knowledge and belief that the answers and statements in this application consisting of all Parts, and any amendments, are true, complete and correctly recorded. I acknowledge that Vantis Life Insurance Company will rely on these answers and statements in determining whether, and on what terms, to issue a policy and that no information about the Proposed Insured will be considered to have been given to the Company for the purposes of issuing the policy unless it is stated in the application, and that the Proposed Insured will notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of the policy.

I understand that if any answers and/or statements are false, incomplete or incorrectly recorded, any policy issued may be void. A sales representative does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable. I agree any policy based on this application shall not take effect and the Company will have no liability unless and until: a) the policy is issued and accepted by me during the lifetime of the Proposed Insured and, b) the first month's full premium is received by the Company at its corporate office in Windsor, CT during the lifetime of the Proposed Insured. I understand that the completion of this application in no way implies that the Proposed Insured will be accepted for insurance coverage.

Fraud Statement: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Insurance products offered by Vantis Life are: NOT deposits, NOT insured by the FDIC/NCUA or any other federal government agency, and NOT obligations of, nor guaranteed by any bank or credit union.

♦ AUTHORIZATION TO RELEASE INFORMATION

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, pharmacy or pharmacy benefit manager, insurance company, consumer reporting agencies, MIB, Inc. ("MIB") formerly known as the Medical Information Bureau, or any similar organization, institution or person that has records of me or my minor children, my employment, and me or my minor children's health to give any such information to Vantis Life or its reinsurers. I understand that the information released to Vantis Life or its reinsurers 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. I authorize Vantis Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. 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 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. I understand that I or my authorized representative is entitled to a photocopy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

X _____ _____

Legal Signature of Proposed Insured (Parent or Guardian, if under age 15) | Date

X _____ _____

Legal Signature of Owner If Other Than Proposed Insured | Date

Owner Signed at:

X _____ _____ _____

Witness | Date | City | State

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