

Investors Heritage *Life Insurance Company*

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P.O. Box 717 Frankfort, KY 40602-0717
Phone: 800-422-2011 Fax: 502-875-7084

Visit our Website:
www.investorsheritage.com

Insured's Full Name: _____ Policy Number(s): _____
 Current Address: _____
 Home Phone: (____) _____ Secondary Phone: (____) _____
 If a telephone interview is required, the best time to call is AM or PM E-mail: _____

APPLICATION FOR REINSTATEMENT

INSTRUCTIONS: Complete separate reinstatement application for each covered person.

To the best of your knowledge and belief, since the date of this policy:

1. Have you been diagnosed by a medical professional with any terminal illness?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Are you currently bedridden at home, confined in a hospital, nursing home, or long-term care facility or receiving Hospice care?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Within the past 10 years, have you had or been treated for, or are you taking medication for any of the following:	
a) Heart disease or disorder, heart attack, stroke, chest pain, heart surgery, angioplasty, high blood pressure, diabetes or congestive heart failure?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Cancer or melanoma, leukemia, kidney failure or dialysis, liver disease or cirrhosis, chronic lung disease, or tuberculosis?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Alzheimer's Disease, Parkinson's Disease, Down's Syndrome, Lou Gehrig's Disease (ALS), Multiple Sclerosis (MS), seizure disorder or any other disorder of the brain or nervous system?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Within the past 10 years, have you ever been diagnosed by a member of the medical profession as having, or have you tested positive for, or been treated by a member of the medical profession, for any of the following: Acquired Immune Deficiency Syndrome (AIDS), Aids Related Complex (ARC), Human Immunodeficiency Virus (HIV Virus), or any other disease or disorder of the immune system?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you been treated for, or been advised to receive treatment for, alcoholism or drug abuse?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Been in a hospital, clinic, or institution for examination, observation, diagnosis, operation or treatment?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Consulted or been treated by any physician or practitioner or had any physical impairment, sickness, injury, surgery or mental disorder not mentioned above?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Had any life or health insurance declined, postponed, or rated or refused reinstatement or renewal?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Had two or more moving violations, or had a driver's license suspended or revoked within the past 5 years?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. Driver's License Number _____ State of: _____	
11. Engaged in or expect to engage in: aviation activities other than a fare paying passenger on commercial lines airlines, motor racing in any form, scuba diving, hang-gliding, cave exploration, parachuting, mountain climbing, rodeo, bungee jumping or ballooning?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
12. Changed occupations? If yes, give present occupations and employers and duties below.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
13. Are you now a cigarette smoker?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. If "YES", number of packs daily? _____	
b. Have you ever been a cigarette smoker and quit?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. If "YES", when did you quit? Date (month/year) _____	
d. Do you use tobacco in any other form? If "YES", Type: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
14. Height: _____ ft. and _____ inches Weight: _____ lbs.	
15. Within the past 12 months, has the Proposed Insured been continuously at work, and able to perform all the duties of their normal occupation (except for normal pregnancy)? If "No", provide details below.	<input type="checkbox"/> YES <input type="checkbox"/> NO

GIVE COMPLETE DETAILS BELOW FOR "YES" #1 -14 ANSWERS ABOVE AND "NO" for #15:

Question Number	Date(s)	DETAILS: Condition, operation performed, hospitalization, medications, other details	Names & addresses of doctors, hospitals or clinics involved

21001-10 (11-2008)

NOTICE OF INFORMATION PRACTICES This Notice To Be Detached and Retained by Insured (Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

Information regarding your insurability will be treated as confidential. Investors Heritage Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Investors Heritage Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

21001-10 (11-2008)

I (We) represent that all statements and answers in this application are full, complete and true to the best of my (our) knowledge and belief. I (we) understand that said statements and answers are submitted as evidence of insurability of each person insured under the policy. It is agreed that this policy will not be reinstated and the company will have no liability until (1) all money required for reinstatement of this policy has been paid; (2) this application has been approved by Investors Heritage Life Insurance Company Home Office during the lifetime of all persons who would be insured under this policy if reinstated. It is further agreed that with regard to the statements and answers provided above, any period of contestability provided in the policy shall run anew from the effective date of reinstatement.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, consumer reporting agency, the Department of Motor Vehicles (or other appropriate state agency), or the Medical Information Bureau that has any records or knowledge of me, to give Investors Heritage Life Insurance Company, or its reinsurer(s), such information as may be needed to consider my application for insurance. Such information may include records or knowledge of my health, credit, motor vehicle records, aviation activities, hobbies or avocations, and occupation. A photographic copy of this authorization shall be as valid as the original. The purpose for which this information is being collected is to consider your application for insurance. You or your authorized representative are entitled to receive a copy of this authorization.

This authorization shall be valid for 24 months from the date shown below. A photographic copy shall be as valid as the original. I have the right to revoke this authorization at anytime by sending a revocation in writing to Investors Heritage Life Insurance Company, PO Box 717, Frankfort, KY 40602-0717. Attention: Underwriting Department. I have received a copy of the Notice of Information Practices.

————— FRAUD NOTICE —————
Required State Disclosures

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Kentucky and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Warning: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All other states: 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 may be guilty of a crime and may be subject to fines, confinement in prison, and denial of insurance benefits.

DATE: _____ Signature of Owner (Always Required)

WITNESS: _____ Signature of Insured, if other than Owner
(or Parent if insured is minor)

21001-10 (11-2008)



NOTICE OF INFORMATION PRACTICES continued

We or our reinsurer(s), may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom a claim is submitted.

In addition, we may get an investigative report from a consumer reporting agency. This report requires personal interviews with your neighbors, friends, or other acquaintances for information as to your general reputation, personal characteristics and mode of living. As part of your application, you have authorized us to do this. You have the right to be personally interviewed and to make a written request within a reasonable period about the nature and scope of this investigation. Upon written request you will be told if such a report has actually been ordered, and if it has, we will give you the name and address of the consumer reporting agency. You may contact this consumer reporting agency and ask for a copy of such report. Unless a legitimate business need exists or we are required to do so by law, the information we get in this report, as well as any other information which we later acquire, will not be disclosed to anyone else without your consent. You may request a copy of all information acquired by us and have a right to correct any personal information which you feel is inaccurate. We will, if required by law, give you a more detailed notice of the types of personal information which we get in considering your application, as well as any additional rights which you may have.

If you need any assistance, please feel free to contact your agent or call or write to us at our Home Office: Investors Heritage Life Insurance Company, Underwriting Department, PO Box 717, Frankfort, KY 40602-0717.

21001-10 (11-2008)