APPLICATION FOR REINSTATEMENT

1116 West Riverside Avenue, P.O. Box 1445, SPOKANE, WA 99210
509-838-4235 800-541-5858 www.nclife.com

This form is not necessary if premium is paid under conditions of Special Late Payment Offer

Policy No.______________________ Insured ____

I hereby apply for reinstatement of my insurance described above, and to induce you to effect such reinstatement. I represent that, to the best of my knowledge and belief, I am (and all others insured under a family plan rider also are) now in sound health and have not during the past five years suffered any illness or undergone any medical or surgical treatment, consultations or check-ups except as follows: (Give name of physician or hospital, with addresses. **If none, so state)**.

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I further agree that such reinstatement shall be effective 12 o'clock noon on the day and date this application is approved by the Company in its Home Office at Spokane, Washington, subject to the payment of all delinquent premiums.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to North Coast Life Insurance Company or its reinsurers, any and all such information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by North Coast Life Insurance Company or its reinsurers to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by North Coast Life Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this authorization shall be as valid as the original and for a period of two and one half years from date shown below.

Signed this _______________ day of _______________________________ 20 ________.

____ Signature of Spouse (if Family /rider included)

____ Signature of Insured

____ Signature of Witness

____ Signature of Owner

Address for mailing notices: (Please Print)

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