PACIFIC GUARDIAN LIFE

Please return for processing to:
CLIENT RELATIONS DEPARTMENT
1440 Kapiolani Boulevard, Suite 1700 Honolulu, Hawaii 96814-3698
(800) 432-3306 Email: clientrelations@pacificguardian.com

Policy Reissue and Reinstatement Application

PART 1. Beneficiary and Policyowner shall be the same as in original policy unless appropriate change forms are submitted.

Policy No.: Social Security No. of Policyowner:

Name of Policyowner if other than insured:

Street Address: City, State, Zip:

1.	Name of all persons proposed for insurance			Relationship	Date of Birth			Place of Birth	Height		
	First	Middle	Last		Mo.	Day	Year		Ft.	In.	Weight
a.				**INSURED**							
b.											
c.											
d.											

2. Occupation of Primary Proposed Insured: Employer:

Street Address: City, State, Zip:

3. Changes	Add/delete the following (3).	Add	Delete
☐ New face amount: **$**	Premium Waiver		
☐ Plan:	Accidental Death Benefit **$**		
☐ Non-smoker	Amount of ADB now in force in all companies **$**		
☐ Death Benefit Option:	Spouse Insurance Rider **$**		
☐ 1 (Level) ☐ 2 (Increasing)	Children's Insurance Benefit **Units:**		
☐ Reinstatement (Enclose Premium payment)	Family Insurance Benefit **Units:**		
☐ Review rating	Other:		

☐ Convert Term Insurance at ☐ Original age ☐ Attained age If partial conversion, balance to: ☐ Be terminated ☐ Remain in force

4. Is premium loan provision to be automatic if available? ☐ Yes ☐ No

5. Premiums to be paid ☐ Annually ☐ Semi-annually ☐ Monthly bank draft ☐ Other:

Planned modal premium amount: **$** Amount paid with application: **$**

6. Other life insurance in force covering Primary Proposed Insured: (If none, so state)

Company	Issue Year	Amount	Accidental Death

7. Will this insurance replace, change or use cash values of any existing insurance policy or annuity issued by any company?
☐ Yes ☐ No If "Yes," give name of company(ies) and policy number(s). Also complete any additional requirements of State where application is signed.

8. Remarks: (Please attach separate sheet as needed.)

Home Office endorsement only.

PART 2. Declaration of Insurability

9. As a basis for such application, I make the following representations and agree that the change requested shall not be effective until it has been approved at the Home Office and any required additional premium has been paid. I represent and certify that no proceedings in insolvency or bankruptcy are now pending against me and that my property is not subject to any assignment for the benefit of creditors.

During the last 10 years, has any person proposed for insurance been treated for or advised of or have knowledge that any of the following specific items are applicable to them?

YES NO

1. a. Consulted or been examined by a physician? ☐ ☐
   b. Illnesses, injuries or operations? ☐ ☐
   c. Use of marijuana, cocaine, heroin and other narcotic drugs or excessive use of alcohol? ☐ ☐
   d. Under current medical treatment or taking any type of medication? ☐ ☐
   e. Change in occupation or participation in any hazardous sports? ☐ ☐
   f. Flown or contemplate flying as a pilot or crew member, military or civilian? ☐ ☐
   g. Made application for insurance which is now pending or has been declined, postponed or modified? ☐ ☐
   h. Lost or gained more than 20 pounds within the past year for reasons other than routine diet or normal growth? ☐ ☐
   i. Used tobacco in any form during the past 12 months? ☐ ☐

2. a. **(Not applicable where prohibited by state law.)** Treated for, counseled for or told you have Acquired Immune Deficiency syndrome (AIDS) of an AIDS Related Comlex (ARC)? ☐ ☐
   b. **(For Nevada and South Dakota only.)** Do you have or ever had any disease or disorder of the immune system? ☐ ☐

3. a. Chest pain, palpitation, high blodd pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or circulatory system? ☐ ☐
   b. Asthma, tuberculosis, bronchitis, emphysema, shortness of breath, persistent cough, pleurisy or other respiratory disorder? ☐ ☐
   c. Diabetes, or sugar, albumin, blood or pus in urine; stone of kidney, ureter or gall bladder; other disorder of genitourinary system or reproductive disorder? ☐ ☐
   d. Cancer, cyst, tumor, lymph gland disorder, anemia or other disease of white or red blood cells, platelets or blood clotting? ☐ ☐
   e. Arthritis, gout or disorder of muscles, bones, spine or joints? ☐ ☐
   f. Ulcer, colitis, intestinal bleeding, jaundice or other disorder of stomach, intestines or liver? ☐ ☐
   g. Epilepsy, convulsions, paralysis, stroke, fainting spells or mental or nervous system disorder? ☐ ☐

4. Other than already listed, have any of you within the past five years:
   a. Had any mental or physical disorder? ☐ ☐
   b. Had check-up, consultation, illness, injury or surgery? ☐ ☐
   c. Been a patient in a hospital, clinic or mental health facility? ☐ ☐
   d. Had any EKG, X-ray or other medical tests (not including HIV tests)? ☐ ☐
   e. Been advised to have any diagnostics test, hospitalization or surgery not yet completed? ☐ ☐

5. With regard to those answered "Yes," give full details below:

Disease or Injury	Date	No. of Attacks	Duration	Results	Names and Addresses of Attending Physicians

6. Name of current personal physician, and date and reason of last visit. Physician's Name:

Date: Reason:

10. Required Signatures-IMPORTANT INSTRUCTIONS.
If the policyowner lives in a community property state, because of the Community Property Laws of these states, this request must also be signed by wife or husband. This signature should be on line "A." If husband or wife is deceased, please show this information on line "A." Owner must sign this application on line provided.

I hereby declare and agree that to the best of my knowledge and belief, all statements and answers to the above questions are complete and true and together with my original application and the application for change of policy are made to induce Pacific Guardian Life to make the requested change. I agree that such statements and answers shall form a part of the contract including the requested change.

Dated at _____ on _____
City, State Date

_____ _____
Signature of Owner Signature of Proposed Insured

_____ _____
Signature of Witness Signature of Spouse/ Joint Insured

PART 3. Agent's Report

1. Did you personally see all proposed insureds and ask each and every question and accurately record their answers yourself? ☐ Yes ☐ No

2. Annual income of Primary Proposed Insured:

Earned $_____ Other $_____

3. The following have been ordered: ☐ Exam ☐ H.O.S. ☐ Blood Profile ☐ EKG ☐ Inspection

4. Agent(s) to receive commision and volume credit:

(Circle letter of agent who is to receive all correspondence.)	Agent Number	Situation Code	Percent of Credit
a.			
b.			

5. Will the requested policy change, if approved, replace an existing policy for life and/ or annuity insurance? If "Yes," submit State required Replacement Notice and/ or Disclosure Statements. ☐ Yes ☐ No

I certify that I have truthfully and accurately recorded on the application the imformation supplied by the proposed insured(s) and personally witnessed the signature of the Primary Proposed Insured and the Owner.

Signature of Agent: **X** _____