Athene Annuity & Life Assurance Company of New York

1 Blue Hill Plz, Ste 1672 • Pearl River, New York 10965

APPLICATION FOR REINSTATEMENT

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND PROPERLY SIGNED
(PLEASE PRINT)

Policy No. _____ Amount paid with this application $ _____

Name of Owner _____

Name of each Insured _____

Name of Payor Insured (if applicable) _____

PLEASE ANSWER EACH QUESTION BELOW FOR ALL INSUREDS COVERED BY THE POLICY HAS ANY INSURED UNDER THIS POLICY OR ANY ATTACHED RIDER, SINCE THE DATE OF THIS POLICY:

1. Been diagnosed or received treatment by a licensed physician for any physical impairment, sickness, operation, mental disorder or injury?
2. A. Height _____ Ft. _____ In. B. Weight _____ Pounds
3. Smoked cigarettes or used tobacco in any other form in the past 12 months?
4. Used barbiturates, heroin, cocaine, marijuana or any other illegal, restricted, or controlled substance except as prescribed by a physician? If Yes, when and how often?
5. a. Been advised to limit or cease the use of alcoholic beverages?
   b. Been counseled, sought help or treatment, or been advised to undergo counseling or treatment for alcohol problems?
6. Had a driver's license restricted, revoked or suspended?
7. Engaged or intend to engage in hang gliding, racing, mountain climbing, skin, scuba or sky diving? If Yes, complete Hazardous Activities Questionnaire.
8. Taken within five years or intend to take flights other than as a fare-paying passenger on scheduled airlines? If Yes, complete Aviation Questionnaire.
9. Been convicted of a felony or misdemeanor within the past 10 years?
10. Applied for new or reinstatement of insurance? (If Yes, give details - companies; amounts; types of insurance; whether pending, issued, refused, postponed, limited or rated).
11. Been diagnosed by or received treatment from a licensed physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

	FIRST INSURED		SECOND PAYOR INSURED		CHILDREN	
	Yes	No	Yes	No	Yes	No
1.	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐	☐
5a	☐	☐	☐	☐	☐	☐
5b	☐	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐	☐
7.	☐	☐	☐	☐	☐	☐
8.	☐	☐	☐	☐	☐	☐
9.	☐	☐	☐	☐	☐	☐
10.	☐	☐	☐	☐	☐	☐
11.	☐	☐	☐	☐	☐	☐

EXPLAIN ANY "YES" ANSWERS; INDICATE QUESTION #, NAME OF INSURED AND SHOW DISORDER, DATE OF ONSET AND RECOVERY, NAME AND ADDRESS OF PHYSICIAN, CLINIC OR HOSPITAL. IF CHILDREN COVERED, LIST NAMES OF CHILDREN BORN OR ADOPTED SINCE DATE POLICY WAS ISSUED. (USE REVERSE SIDE IF NECESSARY)

I agree that any reinstatement of this Policy, as granted by the Company upon this application and any supplements thereto, copies of which shall be attached to and made a part of the reinstated policy, shall be contestable at any time within two years from the date of the approval hereof. I hereby declare that all the above statements are full, complete and true to the best of my knowledge and belief.

Signed at _____ this _____ day of _____ 20 _____

_____ (Witness - not a beneficiary)

_____ OWNER

_____ SECOND INSURED (if Joint Policy)

_____ INSURED

AUTHORIZATION - A photo copy of this authorization shall be as valid as the original, which shall be valid for 24 months. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, LLC ("MIB"), or other organization, institution or person that has any records or knowledge of me or my health to give Athene Annuity & Life Assurance Company of New York or its reinsurers any such information. This includes data related to drugs, alcoholism or mental illness. This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant has AIDS/ARC. **It also includes data obtained in connection with the preparation of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application.** I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. To expedite the collection of data, I authorize all such sources, except MIB, to give the data to any agency employed by Athene Annuity & Life Assurance Company of New York to collect and transmit such data. I further authorize Athene Annuity & Life Assurance Company of New York to prepare or obtain any investigative consumer report in connection with this application; if a consume report is prepared, I elect to be interviewed: ☐ Yes ☐ No I am aware that I am entitled to receive a copy of this authorization form. I may revoke this authorization by filing a written request with the Company.

Date _____

_____ INSURED (or Owner)

_____ SECOND INSURED (if Joint Policy)

_____ PAYOR INSURED

421 (REV. 9/18) VT

NOTICE WITH REGARD TO MIB, LLC

DETACH AND KEEP FOR YOUR RECORDS

MIB Disclosure Notice

Information regarding your insurability will be treated as confidential. Athene Annuity & Life Assurance Company of New York or its reinsurers may, however, make a brief report thereon to the MIB, LLC ("MIB"), 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the 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.

Athene Annuity & Life Assurance Company of New York, or its reinsurers, may also release information from 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.

9/08

ADDITIONAL INFORMATION

I hereby declare that all the above statements are full, complete and true to the best of my knowledge and belief.

Signed at _____ this _____ day of _____ 20 _____

(Witness - not a beneficiary) OWNER

SECOND INSURED (if Joint Policy) INSURED

NOTICE AS REQUIRED BY THE FAIR CREDIT REPORTING ACT
ABBREVIATED NOTICE REGARDING THE INSURANCE INFORMATION PRACTICES

We are required to tell you that a consumer report about you and any other person proposed for insurance may be made; this is in connection with and is a normal part of our processing of your application. The people making the report will talk to your friends, neighbors, family members, co-workers and others having knowledge of you; they will ask about your business and personal life. You have a right to ask us in writing whether such a report was prepared; we must give you the name and address of the Agency which made the report, if any. The Agency will give you a copy of the report if you ask them for it. All information collected by us either from you or other sources may in certain circumstances be disclosed to third parties without authorization more specific than as set forth in this application. You have a right of access and correction with respect to the data, except that which relates to claim or civil or criminal proceeding; or to medical record information. Medical record information may be accessed by a medical professional you designate. Our Underwriting Department will provide a more detailed review of our information practices if you request it.