NATIONAL WESTERN®
LIFE INSURANCE COMPANY

APPLICATION FOR REINSTATEMENT

Policy No. ______________________________

Insured Name ______________________________

The representations made below apply to *each person* who would be insured under this policy if reinstated.

During the past 5 years or since the policy date of this policy (whichever is shorter), has any person that was insured:	YES	NO
1. Used tobacco or any nicotine product?	❒	❒
2. Flown as a pilot or participated in a hazardous sport such as vehicle racing, parachuting, bungee jumping or diving?	❒	❒
3. Used narcotics or other drugs not prescribed by a physician, or been treated by a health care provider for alcohol use?	❒	❒
4. Been convicted of driving under the influence of alcohol or drugs, or is now on parole or probation?	❒	❒
5. Been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), cancer, or heart disease?	❒	❒
6. Consulted a health care provider, or been admitted to a hospital, treatment center, or other facility?	❒	❒
7. Had an x-ray, ECG, blood or urine test, or other diagnostic medical test?	❒	❒
8. Been advised to have surgery, hospitalization, treatment or diagnostic test that has not been completed?	❒	❒
9. Had, or taken medication for any disease, disorder, or condition not indicated above?	❒	❒
10. Requested or received payments or reimbursements for a mental or physical disability?	❒	❒

DETAILS - Use this section to furnish details of "Yes" answers to the questions above.

Question No.	1st Name of Proposed Insured	Date	Details (Include diagnosis, doctor's names and addresses or other details)

If more space is needed, use an additional sheet of paper signed and dated by the proposed insured(s).

Each of the undersigned: Declares that all answers in this application for reinstatement, which is an amendment to the original application and will be part of the policy, are true to the best of their knowledge and belief, and understands that: (a) all answers in this Application for Reinstatement will be relied upon to determine insurability and will be the basis of any insurance issued and any policy reinstated; and (b) a material misrepresentation may void the reinstated policy. The Company may contest a material misrepresentation at any time within two years* from the date the reinstatement is approved at National Western's Office in Austin, Texas. This policy reinstatement will take effect when: (1) the reinstatement application is fully completed, including any amendments required by National Western; and (2) the application for reinstatement is approved at National Western's Office in Austin, Texas; and (3) all due premium has been paid; and (4) each of the prior three conditions is satisfied while the proposed insureds are alive and their health and insurability is as described herein.

Each of the undersigned: Authorizes any licensed physician, medical practitioner, hospital, other health care provider, insurance company or other organization or person to give any information about me or my mental or physical health to the company and/or its authorized agents to determine my eligibility for life insurance coverage. National Western or its reinsurers may also release such information to the MIB or to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. The Medical Information Bureau may furnish directly to National Western or its reinsurers any records or knowledge of me or my health. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photo of this form is as valid as the original. I may have a copy of this form upon request.

Each of the undersigned acknowledges receipt of the Consumer Report Notice, MIB Disclosure Notice, and Information Practices (if applicable).

*One year in Colorado and North Dakota.

✓ ______________________________
Signature of Owner if other than Proposed Primary Insured
(If business insurance, show title of officer and name of firm)

✓ ______________________________
Signature of Proposed Primary Insured
(Parent if age 17 or less)

Signatures of other proposed insureds age 18 or older:

Other Insured #1✓ ______________________________

Other Insured #2✓ ______________________________

Other Insured #3✓ ______________________________

Other Insured #4✓ ______________________________

Signed in ______________________________ Date __________
City State

X ______________________________
Agent/Witness as to all signatures

DETACH AND KEEP THIS NOTICE

DATE____________

NOTICE UNDER THE FAIR CREDIT REPORTING ACT. This is to inform you that, as part of our procedure for processing your Application for Reinstatement, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, but not your sexual orientation. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

MIB DISCLOSURE NOTICE. Information regarding your insurability will be treated as confidential; however, we or our reinsurers may make a brief report thereon to the Medical Information Bureau (MIB), a non-profit organization of life insurance companies which operates an informational exchange for its members. If you apply for life or health insurance, or submit a claim for benefits to any MIB member, the MIB will, upon request, supply such member with the information in its file.

Upon your request, the MIB will disclose any information in your file. If you feel that any information in your MIB file is inaccurate, you may contact the MIB at P.O. Box 105, Essex Sta., Boston, Mass. 02112, Tel. (617) 426-3660, and seek correction in accordance with the procedures set out in the federal Fair Credit Reporting Act. We or our reinsurers may also release information to other life insurance companies to whom you may (1) apply for life or health insurance, or (2) submit a claim for benefits.

NOTICE OF INFORMATION PRACTICES. Residents of Arizona, California, Georgia, Illinois, Montana, North Carolina, Oregon and Virginia must be given and sign an Authorization to Obtain and Disclose Information and Notice of Information Practices [SU-6412(Rev.1/95)].