Capitol Bankers Life

Capitol Bankers Life Insurance Company
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Greenville, South Carolina 29602-9191
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JUL 20 1993

APPLICATION FOR CHANGE OR REINSTATEMENT OF COVERAGE

Policy Number 1009208

Insured Name Simon L. BERNSTEIN

Owner Name Shirley BERNSTEIN

1. Reinstate Policy

☐ Reinstate policy, effective ___/___/___

Complete Health Statement on reverse side.

2. Change Face Amount

☐ Increase* ☐ Decrease

From $ 2 million To $ 3 million

**Complete Health Statement on reverse side.*

3. Change Premium

☐ Increase ☐ Decrease

From $_____ per _____

To $_____ per _____

4. Add Benefits to Policy

Complete Health Statement on reverse side.

☐ Accidental Death Benefit $_____

☐ Additional Insurance Rider $_____

☐ Living Benefits Rider—*Do not complete Health Statement.*

☐ Premium Credit Rider

☐ Waiver of Monthly Deduction

☐ Waiver of Premium

☐ Other Insured Rider $_____

Name _____ D.O.B. ___/___/___

Sex: ☐ M ☐ F Height _____ Weight _____

State of Birth _____ Relationship _____

Primary Beneficiary _____

Relationship to Other Insured _____

Contingent Beneficiary _____

Relationship to Other Insured _____

☐ Spouse Ins. Rider (see below also) $_____

☐ Children's Ins. Rider (see below also) $_____

Names of Spouse/Children to be covered by rider(s)	Date of Birth	Sex	Hgt.	Wgt.

5. Change Death Benefit Option

☐ Change from A to B—*Complete Health Statement.*

☐ Change from B to A

6. Change Smoker Status

Complete Health Statement on reverse side.

☐ Change rates from Smoker to Nonsmoker

I have not smoked cigarettes in the last twelve months. This declaration will entitle Capitol Bankers Life to amend my policy to a Nonsmoker contract.

☐ Please decrease my premium to Nonsmoker rates.

☐ Please continue current premium and apply excess premium to the policy's cash accumulation values.

Insured Signature _____

Witness Signature _____

7. Reduce Policy Rating

☐ Reduce or eliminate rating on policy.

Complete Health Statement on reverse side.

8. Change Plan*

Complete Health Statement on reverse side.

☐ Change plan from _____
Type of Plan

to _____
Type of Plan

☐ Change coverage From $_____

To $_____

☐ Change premium From $_____

To $_____

The Owner and Beneficiary of the new policy will be the same as under the original policy unless indicated below. I surrender to the Company the insurance being changed and request that the new plan be issued in its place effective on the date the original policy is terminated.

**If exercising the policy's conversion privilege, complete the Application for Conversion (form SO-89037) only.*

9. Special instructions or requests

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