SENIOR LIFE INSURANCE COMPANY
PO BOX 2447
THOMASVILLE, GA 31799-2447
877-777-8808

DANGER! YOUR POLICY HAS LAPSED! GRACE PERIOD EXPIRED

REINSTATEMENT OFFER APPLICATION

As of _____, your premium due was not received. It is very important to take care of this so your loved ones will be taken care of at the time of need. Application for reinstatement below must be completed and is subject to approval by Senior Life Insurance Company.

INSURED: _____ POLICY#: _____ ISSUE BASIS: Term 20 ROP
DUE DATE: _____ PREMIUM: _____ INTEREST: _____ TOTAL: _____ MONTHS: _____

Please answer the following questions or provide information where indicated:	YES	NO
1. Have you used any form of tobacco or nicotine product in the past twelve months?	❑	❑
2. Are you currently hospitalized, confined to a nursing facility, receiving hospice or home health care, unable to care for yourself, terminally ill, or incarcerated; have you been hospitalized two or more times in the past three years; or do you expect to be admitted to a hospital or nursing facility in the next twelve months?	❑	❑
3. Have you tested positive for exposure to the HIV (Human Immunodeficiency Virus) Infection or been diagnosed as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV (Human Immunodeficiency Virus) Infection or other sickness or condition derived from such infection?	❑	❑
4. In the past five years, have you been advised or recommended to have any test, procedure, surgery, or hospitalization which has not been received or completed, or been advised to take medications and have not been compliant?	❑	❑
5. In the past five years, have you used any illegal drugs or excessively used drugs or alcohol, or have you been treated for or advised to have treatment for drug or alcohol abuse?	❑	❑
6. In the past five years, have you had, received medical advice for, or been treated for, diagnosed with, or prescribed medication for any of the following:		
A. Cancer; stroke; coronary artery disease; any lung disease, including COPD (Chronic Obstructive Pulmonary Disease)/emphysema; or any disease or disorder of the heart, brain, liver, or circulatory system?	❑	❑
B. Chronic kidney disease or kidney failure; muscular disease; mental disorder; seizure disorder; uncontrolled high blood pressure; or uncontrolled diabetes, including any complications from such?	❑	❑
C. Disorder of the nervous system or any impairment, disorder, disease, transplant, or chronic illness?	❑	❑
7. A. Please provide your physician's name and location: _____		
B. Have you taken any medications in the past five years? If yes, please list their names and usage, including any medications you are currently taking: _____	❑	❑

I have read or have been read all questions and answers, and I affirm that they are true to the best of my knowledge and belief. I understand that for this insurance to go into effect, the Proposed Insured's health condition must remain as described in the application at the time the first premium is honored by the bank and the policy is issued. I also understand that Senior Life Insurance Company will rely on my answers above in issuing any life insurance hereunder and that the agent does not have the authority to waive or modify any question or answer. **We will provide information regarding the benefits and provisions of this policy within ten (10) days of the receipt of a written request for such information at our Executive Office.** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Insured _____ Phone # (_____) _____

Signed in _____ on _____, 20____ Signature of Witness _____