

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

**DANGER! YOUR POLICY HAS LAPSED!**  
**REINSTATEMENT OFFER APPLICATION**

GRACE PERIOD EXPIRED

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  
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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Disorder of the nervous system or any impairment, disorder, disease, transplant, or chronic illness? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: _____   | <input type="checkbox"/> | <input type="checkbox"/> |

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 \_\_\_\_\_