

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: Ultimate PFD WL
DUE DATE: _____ PREMIUM: _____ INTEREST: _____ TOTAL: _____ MONTHS: _____

- YES NO Are you currently hospitalized, confined to a nursing facility, receiving hospice care, unable to care for yourself, terminally ill, incarcerated, legally blind, wheelchair bound, or bedridden; in the past ten years, have you been hospitalized two or more times or received home health care; or do you expect to be admitted to a hospital or nursing facility?
- YES NO Have you tested positive for the presence of HIV (Human Immunodeficiency Virus) antibodies, antigens, or the virus or ever been diagnosed or treated by a licensed medical professional for ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV (Human Immunodeficiency Virus) Infection?
- YES NO In the past twelve months, have you experienced any unexplained weight loss or weight gain?
- YES NO In the past ten years, have you used any form of tobacco or nicotine product or had a blood pressure reading over 135/85?
- YES NO In the past ten years, have you been advised or recommended to have any tests, treatment, surgery, or hospitalization which has not been received or completed, or advised to take medications and have not been compliant?
- YES NO In the past ten years, have you had, been treated for, received medical advice or been prescribed medication for, or been diagnosed with diabetes; high blood pressure; stroke; paralysis; cancer; any heart, organ, or lung disease (including COPD (Chronic Obstructive Pulmonary Disease)/emphysema); mental disorder/retardation; disorder of the brain or nervous system; or any impairment, disorder, disease, transplant, or chronic illness?
- YES NO Have you used illegal drugs, been treated for drug/alcohol abuse, been advised by a physician to reduce alcohol consumption, been noted to excessively consume alcohol, or been arrested for any reason?

PHYSICIAN NAME AND ADDRESS: _____

MEDICATIONS AND USAGE: _____

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 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. 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 _____