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: Guaranteed Issue
DUE DATE: _____PREMIUM: _____INTEREST:_____TOTAL: _____MONTHS:____

GUARANTEED ISSUE – NO HEALTH INFORMATION REQUIRED

You must make a payment of _____ prior to _____ to be considered for reinstatement. Please select your desired method of payment:

- ❑ Checking account Routing No: _____ Account No: _____
- ❑ Money Order
- ❑ VISA or MasterCard Credit Card No: _____ Expiration Date:_____/_____

Please print name as it appears on checking account or credit card:_____

I authorize any physician, medical practitioner, hospital, clinic, Veteran's Administration, pharmacy, pharmacy benefit manager, laboratory, any other medically-related person or facility, the MIB, Inc., or consumer reporting agency to furnish Senior Life all information it holds that pertains to any health and/or treatment information, pharmacy prescription drugs, drugs or alcoholism, or any other non-health (non-medical) history information about the proposed Insured to determine eligibility for insurance and/or benefits. Any information used will be subject to the Company's Privacy Policy which is provided with my policy, or upon request. I understand that this Authorization shall remain in force for 24 months following the date of my signature below and may be revoked at any time by sending a written request to the Company. A copy of this Authorization is as valid as the original and a copy will be provided upon request. **Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.** I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the Company will rely on my answers in issuing the insurance. I understand that coverage takes effect when this application has been approved by the Company and the first premium is paid. I authorize, until I revoke in writing, my bank/financial institution to deduct future payments for this insurance by electronic or other means directly from my account identified above.

Owner Insured & Payor Must Sign Here

_____

Insured – Payor/Owner if different than Insured *State Signed In* *Date*