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

YOUR POLICY HAS LAPSED! GRACE PERIOD EXPIRED
REINSTATEMENT OFFER APPLICATION

As of _____, your premium due was not received. 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*