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

GRACE PERIOD HAS EXPIRED.

DANGER! YOUR POLICY HAS LAPSED!

REINSTATEMENT OFFER APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE

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. The Application for Reinstatement below must be completed and is subject to approval by Senior Life Insurance Company.

INSURED: _____ POLICY#: _____ ISSUE BASIS: Easy Issue

DUE DATE:_____PREMIUM:_____ INTEREST:_____TOTAL:_____ MONTHS:_____

❑ YES ❑ NO Are you currently hospitalized, confined to a nursing facility, receiving hospice care, incarcerated, been diagnosed by a member of the medical profession as having an illness expected to result in death in the next twelve months, or been hospitalized two or more times in the past six months; do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living, bathing, toileting, eating, dressing, taking medications, or moving without any type of physical assistance, or been advised by a medical professional to be admitted to a hospital or nursing facility in the next six months?

❑ YES ❑ NO Have you been diagnosed by a member of the medical profession, or tested positive for HIV Infection or AIDS?

Current Medications and Usages: _____

Doctor's Name: City: Phone: ( )

You must include a payment of _____ prior to _____ with this completed Reinstatement Offer Application to be considered for reinstatement. Please select your desired method of payment:

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

Please print name as it appears on your bank account or card:

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.

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 from the date the authorization is signed for the amount of time permitted by applicable law in the state where the contract is delivered or issued for delivery 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.

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 when reinstating the insurance. I understand that coverage takes effect when this application has been approved by the Company and the above referenced premium is paid. 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.

Owner, Insured, & Payor Must Sign Here!

Insured, Payor, and Owner, if different than Insured, must sign here. *Date* *State Signed In*