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

GRACE PERIOD EXPIRED

DANGER! YOUR POLICY HAS LAPSED!
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: Super Preferred

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, or incarcerated; in the past five years, have you been hospitalized two or more times; or do you expect to be admitted to a hospital or nursing facility?

❑ YES ❑ NO Have you tested positive for exposure to the Human Immunodeficiency Virus (HIV) Infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV Infection or other sickness or condition derived from such infection?

❑ YES ❑ NO In the past six months, have you experienced any unexplained weight loss or weight gain?

❑ YES ❑ NO In the past five years, have you used any form of tobacco or nicotine product?

❑ YES ❑ NO In the past ten years, have you been advised or recommended to have any tests, 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 prescribed medication for, or been diagnosed with uncontrolled diabetes, including any complications from such; uncontrolled 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 In the past ten years, 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?

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:

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ARBITRATION

1. THE POLICY FOR WHICH YOU ARE APPLYING INCLUDES A BINDING ARBITRATION AGREEMENT. 2. THE ARBITRATION AGREEMENT REQUIRES THAT ANY DISAGREEMENT RELATED TO THIS POLICY MUST BE RESOLVED BY ARBITRATION AND NOT IN A COURT OF LAW. 3. THE RESULTS OF THE ARBITRATION ARE FINAL AND BINDING ON THE INSURED AND THE INSURANCE COMPANY. 4. IN AN ARBITRATION, AN ARBITRATOR, WHO IS AN INDEPENDENT, NEUTRAL PARTY, GIVES A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES. 5. WHEN THE INSURED ACCEPTS THE INSURANCE POLICY THE INSURED AGREES TO RESOLVE ANY DISAGREEMENT RELATED TO THE POLICY BY BINDING ARBITRATION INSTEAD OF A TRIAL IN COURT INCLUDING A TRIAL BY JURY. 6. ARBITRATION TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY AND THE DECISION OF THE ARBITRATOR CANNOT BE REVIEWED IN COURT BY A JUDGE AND JURY.

HIPAA AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION TO SENIOR LIFE INSURANCE COMPANY

I authorize any health care provider, plan, or clearinghouse, insurance company, pharmacy, pharmacy benefit manager, Medicare or Medicaid agencies or the Medical Information Bureau, or Consumer Reporting Agency to disclose to Senior Life all your medical records, and including information on medical consultations, treatments, surgeries, or hospital confinements for physical and mental conditions, use of drugs, alcohol, or tobacco, prescription drugs, communicable disease such as HIV or AIDS, but excludes psychotherapy notes. This information will be used by Senior Life to determine eligibility for insurance and administer coverage. Other entities to which this information may be disclosed may not be covered by federal privacy rules and if this information is re-disclosed, it may no longer be protected by those rules. This authorization will be valid 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. A copy of this authorization shall be as valid as the original. You are entitled to receive a copy of this authorization. You may revoke this authorization at any time by sending written notice to Senior Life, but any action taken in reliance on this authorization cannot be reversed. By verbally or physically signing this Application I hereby sign and agree to the HIPAA authorization.

BANKING AUTHORIZATION

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.

ACKNOWLEDGMENT OF APPLICATION

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 or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Owner, Insured, & Payor Must Sign Here!

Insured Phone: _____ Insured SSN: _____

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