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

I authorize any physician, medical practitioner, hospital, medical care facility, Veteran's Administration, pharmacy, pharmacy benefit manager, laboratory, or any other medically-related person or facility to furnish any health and/or treatment information about the proposed Insured to Senior Life Insurance Company 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, the first premium is paid, and the policy is issued.

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.

Owner Insured & Payor Must Sign Here

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