

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: Modified WL

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, incarcerated or have you been hospitalized two or more times in the past six months, or do you expect to be admitted to a hospital or nursing facility?
- YES  NO Have you tested positive for exposure to the HIV (Human Immunodeficiency Virus) Infection or been diagnosed as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV (Human Immunodeficiency Virus) Infection or other sickness or condition derived from such infection?
- YES  NO Are you legally blind, wheelchair bound, bedridden, on oxygen, or receiving home health care?
- YES  NO In the past two years, have you used illegal drugs, been treated for drug/alcohol abuse, been advised by a physician to reduce alcohol consumption, or noted to excessively consume alcohol?
- YES  NO In the past two years, have you had, been treated for, received medical advice by a licensed medical practitioner, been prescribed medication for, or been diagnosed by a licensed medical provider with any heart **and** any lung disease/condition/disorder, any blood, kidney or liver disease/condition/disorder, Alzheimer's disease, cancer, cerebral palsy, cystic fibrosis, dementia, Huntington's disease, Lou Gehrig's disease, multiple sclerosis, muscular dystrophy, paralysis, stroke or transplant, uncontrolled high blood pressure (or with complications), uncontrolled diabetes (or with complications)?

PHYSICIAN NAME AND ADDRESS: \_\_\_\_\_

MEDICATIONS AND USAGE: \_\_\_\_\_

I have been read all questions and answers, and I affirm that they are true to the best of my knowledge and belief. I understand that for this insurance to go into effect the Proposed Insured's health condition must remain as described in the application at the time the first premium is honored by the bank and the policy is issued. I also understand that Senior Life Insurance Company will rely on my answers above in issuing any life insurance hereunder, and the agent does not have the authority to waive or modify any question or answer. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Owner \_\_\_\_\_ Signature of Insured \_\_\_\_\_  
(if other than Owner)

Signed in \_\_\_\_\_ on \_\_\_\_\_, 20\_\_\_\_ Signature of Witness \_\_\_\_\_

Phone # (\_\_\_\_\_) \_\_\_\_\_