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

YOUR GRACE PERIOD HAS 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 in their time of need. The below Application must be completed and is subject to approval by Senior Life Insurance Company. Please complete all of the health questions below by checking either yes or no.

INSURED: _____ POLICY#: _____ ISSUE BASIS: Preferred WL

DUE DATE: _____ PREMIUM: _____ INTEREST: _____ TOTAL: _____ MONTHS: _____

PLEASE ANSWER THE FOLLOWING HEALTH QUESTIONS.

❑ 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 three 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 year, have you used any form of tobacco or nicotine product?

❑ YES ❑ NO In the past five 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 five 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 five 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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HIPAA AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION TO SENIOR LIFE INSURANCE COMPANY
I authorize any health care provider, plan, or clearinghouse; insurance company; pharmacy or pharmacy benefit manager; the Medical Information Bureau; or Consumer Reporting Agency to disclose to Senior Life Insurance Company all of my medical records, including information on medical consultations; treatments; surgeries; hospital confinements; use of drugs, alcohol, or tobacco; prescription drugs; and communicable diseases. This information will be used by Senior Life to determine your eligibility for the insurance that you applied for and administer your coverage. Other entities to which this information may be released to 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 expire in twenty-four (24) months. A copy of this authorization shall be as valid as the original. You, or your authorized representative, are entitled to receive a copy of this authorization. You may revoke this authorization at any time by sending written notice to Senior Life. Any action that was taken in reliance on this authorization cannot be reversed. By verbally or physically signing this application I hereby sign and agree to this authorization.

BANKING AUTHORIZATION
I authorize my bank or financial institution to deduct future payments by electronic or other means directly from my account identified above. This authorization will be valid until I request in writing that it be cancelled. If a check is provided as payment, the Company may either use the information from my check to make a one-time electronic fund transfer from my account or they may process the payment as a check transaction. I understand funds may be withdrawn from my account as soon as the same day; my check will not be returned to my bank or financial institution.

ACKNOWLEDGMENT OF APPLICATION
I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that Senior Life will rely on the answers I gave above when reinstating the insurance. I understand that coverage takes effect when this application has been approved by the Company and the total 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*