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: Easy Issue 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, or incarcerated; 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?

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: _____

Continued on Back

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, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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 for thirty months from the date the authorization is signed. 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.

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*