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.

INSURED: _____ POLICY#: _____ ISSUE BASIS: Super PFD 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 five years or expect to be admitted to a hospital or nursing facility?
- ❑ YES ❑ NO Have you tested positive for exposure to the HIV Infection or been diagnosed as having ARC or 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 or had a blood pressure reading over 135/85?
- ❑ 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, 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/Emphysema), mental disorder/ retardation, disorder of the brain or nervous system, any impairment, disorder, disease, transplant or chronic illness?
- ❑ YES ❑ NO Have you used illegal drugs, been treated for drug/alcohol abuse, been advised by a physician to reduce alcohol consumption, noted to excessively consume alcohol or been arrested for any reason?

PHYSICIAN NAME AND ADDRESS: _____

MEDICATIONS & 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 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. I understand that 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)

Phone # (_____) _____

Signed in _____ on_____, 20___ Signature of Witness _____