

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: Preferred 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; 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, 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 from the date the authorization is signed for the amount of time permitted by applicable law in the state where the contract is delivered or issued for delivery. 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.

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 knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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