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 & 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 further acknowledge that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature of Owner _____

Signed in _____ on _____, 20___ Signature of Witness _____

Signature of Insured _____ Phone # (_____) _____
(if other than Owner)