

**REINSTATEMENT APPLICATION FOR MEDICARE SUPPLEMENT POLICY**

Policy Number \_\_\_\_\_ Med Supp Plan \_\_\_\_\_

Applicant: \_\_\_\_\_

SEX: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

2<sup>nd</sup> ADDRESSEE MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

PAYMENT ENCLOSED: \_\_\_\_\_ CIRCLE YOUR FUTURE  
PAYMENT METHOD: BANK DRAFT OR BILLING

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**REINSTATEMENT QUALIFICATION INFORMATION  
CIRCLE YOUR ANSWER**

**PREMIUM CLASSIFICATION QUESTION**

1) Have you used any form of tobacco in the past five years? Yes No

**HEALTH CERTIFICATION QUESTIONS**

2) Are you bedridden or confined to a wheelchair? Yes No

3) Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year? Yes No

4) Within the past two years, have you been advised by a member of the medical profession to have kidney dialysis? Yes No

5) Within the past two years, have you been diagnosed or treated by a member of the medical profession for a heart attack, stroke, TIA or heart surgery? Yes No

6) Within the past two years, have you been diagnosed or treated by a member of the medical profession for internal cancer, leukemia, or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease, dementia, or alcohol or drug abuse? Yes No

7) Within the past two years, have you been advised by a member of the medical profession to have surgery for cataracts, joint replacement, a heart condition, or other in-patient surgery but not had such surgery? Yes No

8) Have you had or been told by your physician you have emphysema, chronic bronchitis, other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis or paralysis? Yes No

9) Within the past five years, have you been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection? Yes No

10) Have you had or been told by your physician you needed amputation due to disease? Yes No

10) Are you an insulin dependent diabetic? Yes No

11) Are you currently taking any medications? Yes No  
If yes, please list them below and indicate the condition for which it is used:

Current Medications and Usages: \_\_\_\_\_

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I hereby apply to Lincoln Heritage Life Insurance Company for reinstatement of my policy to be reinstated based upon my answers to the questions above. The answers are, to the best of my knowledge and belief, true.

\_\_\_\_\_  
Date  
MS-RNSFORM-FL 2006

\_\_\_\_\_  
Signature of Applicant