

**REINSTATEMENT APPLICATION FOR MEDICARE SUPPLEMENT POLICY**

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

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

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

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 to have kidney dialysis? Yes No

5) Within the past two years have you had a heart attack, stroke, TIA or heart surgery? Yes No

6) Within the past two years, have you had or been treated 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 to have surgery for cataracts, joint replacement, a heart condition, or other in-patient surgery but not had such surgery? Yes No

8) Within the past ten years 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, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

9) Within in the past ten years 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: \_\_\_\_\_

**WARNING: Any person who, with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

**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

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