

**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**

I understand that said policy will not be reinstated until this application has been approved by the company at its Home office. The following representations may be used as a basis for contest of a claim for not more than two (2) years after the date of such representation.

**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 been treated by a member of the medical profession for internal cancer, leukemia, 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, paralysis, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

9) 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 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 a criminal and civil penalties.

Any insurance reinstated from this application will take effect on the date of the application or on the date the requested medical information, if any, is received, as long as the proposed insured's health represents a risk acceptable to the company.

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