Lincoln Heritage Life Insurance Company
Executive Offices
4343 E Camelback Road
Phoenix AZ 85018

APPLICATION FOR REINSTATEMENT

REDATE ☐

Insured(s)____ Policy # __________________________

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. If any answer is YES, please indicate which insured.

1) Is any insured currently, or in the past 90 days, been hospitalized, bedridden, confined to a nursing facility, received hospice care or used oxygen to assist in breathing? ☐ YES ☐ NO

2) Within the past 90 days, has any insured had a heart attack, stroke, ALS (Lou Gehrig's disease) or received treatment (including surgery, radiation or chemotherapy) for internal cancer? ☐ YES ☐ NO

3) Has any insured been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ YES ☐ NO

4) Has any insured been diagnosed with a terminal illness? ☐ YES ☐ NO

5) In the past two (2) years, has any insured had, taken medication for or been treated for any of the following? (please circle the condition/conditions)

Alcoholism	Dementia	Kidney Disease	Multiple Sclerosis
Alzheimer's Disease	Drug Abuse	Leukemia	Organic Brain Syndrome
Angina Pectoris	Heart Attack	Liver Disease	Parkinson's Disease
Aneurysm	Heart Disease	Lung Disease	Sickle Cell Anemia
Cirrhosis	Heart Surgery	Lupus	Stroke
Congestive Heart Failure	Internal Cancer	Malignant Melanoma	

☐ YES ☐ NO

5a) An amputation caused by disease, had or been advised to have surgery for a heart condition or blood vessel disease? ☐ YES ☐ NO

5b) Tested positive for Human Immunodeficiency Virus (HIV)? ☐ YES ☐ NO

5c) Had a diagnostic test for which results have not been received? ☐ YES ☐ NO

5d) Uncontrolled high blood pressure **OR** uncontrolled diabetes? ☐ YES ☐ NO

5e) Both controlled high blood pressure **AND** insulin dependent diabetes? ☐ YES ☐ NO

5f) *(Applies to insureds Age 25 and under only)* Cerebral Palsy, Cystic Fibrosis, Diabetes, Down's Syndrome, Multiple Sclerosis or Muscular Dystrophy? ☐ YES ☐ NO

6) Is any insured taking any medications? If so, list medication(s) and usage(s) below and indicate insured who is taking:

Current Medications and Usages:____

____

Describe illnesses or injuries:____

____ Date of onset:___________________________

Doctor's Name and Address: ________________________________Doctor's Phone # (______)_________________

Date(s) of Hospitalization(s):____

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 have read the above questions and answers. I affirm that they are true to the best of my knowledge and belief. I understand that the Company will rely on my answers above in reinstating any life insurance hereunder.

If previously on Automatic Bank Draft/PreAuthorized Payment plan, do you wish to resume? ☐ YES ☐ NO

Signature of Owner:____ Date:___________________

Signature of Insured(s):____

ALL ADULTS INSURED MUST SIGN THIS FORM