

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)**

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

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) 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): _____

Any person who knowingly and with intent to defraud any insurance company or other persons, 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 issued 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 at the rate and in the amount stated in the application, and the first premium is paid, and coverage with the Company, including coverage herein applied for does not exceed \$20,000.

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): _____