

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): _____

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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): _____