Lincoln Heritage
LIFE INSURANCE COMPANY

APPLICATION FOR REINSTATEMENT
PLEASE PRINT LEGIBLY

Executive Offices:
4343 East Camelback Road, Suite 400
Phoenix, AZ 85018-2705

REDATE ☐ Policy #

INSURED(S) INFORMATION

Insured(s) First Name | M.I. | Last Name

Social Security # - -

Secondary Addressee (For the purpose of notification of a past due premium payment and possible lapse in coverage)

First Name | M.I. | Last Name | Phone # - -

Address | Apt. # | City | State | Zip

I understand that said policy will not be reinstated until this application has been approved and the necessary premium has been received by the Home Office. The following representations may be used as a basis for contestability of a claim for not more than two (2) years after the date of such representation.

All applicants must permanently reside in the United States.

1. Is any proposed insured bedridden, incarcerated, in a care facility, receiving hospice care, or has ever been diagnosed by a physician as having a terminal illness? ☐ Yes ☐ No
2. Has any proposed insured been hospitalized in the past ninety (90) days? ☐ Yes ☐ No
3. In the past two (2) years, has any proposed insured been diagnosed by a member of the medical profession with a disease of the heart, lungs, liver, kidney, circulatory or immune system, or with any form of internal cancer, or disease of the immune system (excluding AIDS/HIV/ARC) or used oxygen to assist in breathing? ☐ Yes ☐ No
4. Has any proposed insured been tested positive for exposure to the HIV infection, or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No

If "yes" to any question, please explain:

I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case, it may not be protected under federal privacy rules. This authorization shall be valid for two (2) years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance Company.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the Company will rely on my answers in issuing the insurance.

If previously on Automatic Payment Plan, do you wish to resume? ☐ **Yes** ☐ **No**

Draft my account/card on file for reinstatement/redate payment:
☐ **As soon as possible upon receipt at Home Office**
☐ **On or after** - - **20**

Signature of Owner | Date - - **20**

Signature of Insured(s) If fifteen (15) years or older | Date - - **20**

FOR PRODUCER USE ONLY

I confirm that the Owner and Insured(s) answered and completed this application for reinstatement of the policy listed.

Signature of Producer | Producer's Number -

Printed First Name | Printed Last Name | Florida License Number