



APPLICATION FOR REINSTATEMENT

PLEASE PRINT LEGIBLY

Executive Offices:

4343 East Camelback Road, Suite 400
Phoenix, AZ 85018-2705
Fax: (602) 808-0521
Email: service@lhlic.com
Policy Portal: service.lhlic.com

REDATE <input type="checkbox"/>	Policy #	-
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INSURED INFORMATION

First Name	M.I.	Last Name
Social Security #	-	-

Secondary Addressee (Name, Address and Phone Number)

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.

- 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
 - Has any proposed insured been hospitalized in the past ninety (90) days? Yes No
 - In the past two (2) years, has any proposed insured been diagnosed with, been treated by a member of the medical profession, or taken medication for any of the following conditions:
 - A disease of the heart, lungs, liver, kidney, circulatory or immune system (except for previous HIV tests), or with any form of internal cancer, or used oxygen to assist in breathing? Yes No
 - Human Immunodeficiency Virus (HIV)? Yes No
 - Alcohol or drug abuse? 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.

Visit lhlic.com for information regarding our data collection and privacy information.

**For your protection California Law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Draft my account/card on file for reinstatement/redate payment:	<input type="checkbox"/> As soon as possible upon receipt at Home Office <input type="checkbox"/> On or after

Signature of Owner	Date	-	-	20
Signature of Insured(s)	Date	-	-	20

If eighteen (18) years or older

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