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

Lincoln Heritage® LIFE INSURANCE COMPANY

APPLICATION FOR REINSTATEMENT

Please Print Legibly

REDATE ☐ **Policy #**

INSURED INFORMATION

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 with, been treated by a member of the medical profession, or taken medication for any of the following conditions:
   a. A disease of the heart, lungs, liver, kidney, circulatory or immune system (except for previous HIV tests), or cognitive disease or with any form of internal cancer, or used oxygen to assist in breathing? ☐Yes ☐No
   b. Alcohol or drug abuse? ☐Yes ☐No
4. Has any proposed insured been diagnosed by a licensed medical professional as having 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.

If you do not sign this application Lincoln Heritage Life Insurance Company will not be able to process the reinstatement of your coverage and it may be a basis for denying this reinstatement application.

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) | Date - - 20

If fifteen (15) 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 -

Printed First Name | Printed Last Name | Florida License Number