Lincoln Heritage
LIFE INSURANCE COMPANY

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

APPLICATION FOR REINSTATEMENT

PLEASE PRINT LEGIBLY

REDATE ☐ Policy #

Insured(s)

Insured(s) Social Security Number

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 used oxygen to assist in breathing? ☐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.

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 _____/_____/_____

Signature of Owner _____ Date _____

Signature of Insured(s) _____ Date _____
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 _____