

APPLICATION FOR REINSTATEMENT

Application is hereby made for Reinstatement of Policy Number _____

on _____ which lapsed for non-payment of premium due _____

Present Address: House Number _____ Street _____

(Name of Insured)

City _____ State _____ Zip _____

(1) State the present occupation and full duties of the insured _____

 (2) Have you or any person insured under this policy had an injury, illness, or disease and/or have you or any person under this policy consulted any physician since date of original application? Yes No If Yes, give detail below.

Disease, Injury or Operation	Date	Duration	Name of Physician (if none, so state)	Address of Physician

 (3) Have you or any person insured under this policy ever used narcotics or alcohol excessively, or received treatment for drug addiction or alcoholism? (Not required for Cancer Insurance Reinstatement) Yes No If Yes, give detail below.

(4) If application is for reinstatement of health insurance, state the amount of such insurance carried by you with other companies.

Mo. Income – Accident _____ Sickness _____

Hospitalization – Room _____ Surgical _____

Miscellaneous _____

I represent that the above statements are true and correct and that this APPLICATION FOR REINSTATEMENT shall form the basis and become a part of the reinstated policy.

I further agree that said policy shall not be considered reinstated until this application shall be approved by the Company at its Home Office during the lifetime and good health of all persons insured under this policy, and that any premium paid in advance, or any receipt therefore, shall not be binding upon the Company until this application is approved. If said policy is not reinstated, I agree to accept the return of all advance payments made in connection with this application, without interest, and to surrender the receipt received for such sums.

NOTICE
Printed in Compliance with Public Law 91-508

This is to inform you that as part of our procedure for processing your insurance application an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the American Public Life Insurance Company or its reinsurers any such information.

A photographic copy of this authorization shall be as valid as the original.

Signed at _____

Date _____

Witnessed by _____

Signature _____

 Action: Approved Declined by _____ Date _____