

APPLICATION FOR REINSTATEMENT OF CANCER INSURANCE

Insured's Name _____ Policy Number _____

Present Address: House Number _____ Street _____
City _____ State _____ Zip _____
Date of Lapse _____ Reinstatement Premium enclosed \$ _____**Representation and Agreement of Applicant:**

- (1) I hereby represent that to the best of my knowledge, information and belief, no person to be insured has now or has ever been diagnosed and/or treated for:
- (a) **Cancer and Specified Disease:** Cancer in any form, Adrenal Hypofunction (Addison's Disease), Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Cystic Fibrosis, Diphtheria, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Osteomyelitis, Poliomyelitis, Reye's Syndrome, Sickle Cell Anemia, Tay-Sachs Disease, or Tuberculosis except: _____ (Name of person who will be excluded from coverage; **if none, write none**).
- (b) **Intensive Care/Coronary Care:** Heart attack, Heart condition, Heart trouble, or any abnormal condition of the heart or disease of the circulatory system, stroke, cancer in any form, or diabetes, except: _____ (Name of person who will be excluded from coverage; **if none, write none**).
- (c) No person to be insured is now more than six months pregnant, except: _____ (Name of person who will be excluded from coverage; **if none, write none**).
- (2) I hereby represent that to the best of my knowledge, information and belief, no person to be insured has now or ever has been diagnosed and/or treated for an immune deficiency disorder, AIDS, the AIDS related complex (ARC) or test results indicating exposure to the AIDS virus? Except: _____ (Name of person who will be excluded from coverage; **if none, write none**).
- (AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes) loss of appetite, weight loss, fever, nightsweats, diarrhea, malaise, lethargy and tiredness, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorder with no known causes).

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.

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, 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. This Authorization shall remain in effect for twenty-four months from the date shown below. A photographic copy of this authorization shall be as valid as the original.

Signed at _____ Date _____

Witnessed by _____ Signature _____

Action: Approved Declined by: _____ Date _____