

Application for Reinstatement

Policy # _____

Principal Insured	Date of Birth	Attained Age
Street Address		Phone Number
City/State/ZIP		Social Security Number

	No	Yes
1. Has any person covered by this policy smoked tobacco or used tobacco in any form in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is any person covered by this policy now pregnant? Any miscarriages or complications of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any person covered by this policy ever:		
A. Been convicted of a felony?	<input type="checkbox"/>	<input type="checkbox"/>
B. Been arrested for driving while intoxicated, had a drivers license suspended or revoked or had a moving violation in the last three years?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any person covered by this policy:		
A. Made or intend to make any flights as a pilot, student pilot, or crew member?	<input type="checkbox"/>	<input type="checkbox"/>
B. Engaged or intend to engage in any sport or activity such as auto or motorcycle racing, skydiving, or scuba diving?	<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes to A or B, please explain:		
5. Has any person covered by this policy been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has any person covered by this policy, during the past 5 years:		
A. Had kidney disease; blood, pus or sugar in the urine; prostate trouble; or any genito-urinary disorder or venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>
B. Used, or been treated for abuse of sedatives, hallucinogenics, drugs, or alcohol, not otherwise prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
C. Had any bone or joint disorder or disease, tumor, cancer, tuberculosis, or seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>
D. Had anemia, leukemia, or other disease of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
E. Had any diabetes, liver disorder, ulcers, or other digestive disorder or disease?	<input type="checkbox"/>	<input type="checkbox"/>
F. Had any heart or circulatory disease, chest pain, stroke, hypertension, hernia, mental or nervous disorder, asthma, lung disease, or other respiratory disease?	<input type="checkbox"/>	<input type="checkbox"/>
G. Been a patient in or advised to enter a hospital, sanitarium, nursing home, or other institution for any reason, or had an operation?	<input type="checkbox"/>	<input type="checkbox"/>
H. Had a checkup, or currently taking any prescription drug (please list)?	<input type="checkbox"/>	<input type="checkbox"/>
I. Had any disease, condition, or other physical disorder or defect not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>

Continued on other side.

