



**U.S. FINANCIAL LIFE INSURANCE COMPANY  
REQUEST FOR POLICY REINSTATEMENT FOR POLICY #**

POLICY OWNER \_\_\_\_\_

INSURED \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SSN# \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PLEASE NOTE ANY CHANGE OF ADDRESS ABOVE

**IMPORTANT: ANSWER ALL THE QUESTIONS BELOW AND SIGN ON THE BOTTOM. PROVIDE DETAILS TO ANY "YES" ANSWERS IN THE SPACE PROVIDED. ATTACH AN ADDITIONAL SHEET IF NECESSARY.**

1. HAVE YOU USED TOBACCO IN ANY FORM IN THE PAST 12 MONTHS?  YES  NO

2. HAVE YOU EVER OR DO YOU ANTICIPATE IN THE NEXT TWO YEARS PARTICIPATION:

A. AS A PILOT OR MEMBER OF THE CREW OF ANY TYPE OF AIRCRAFT?  YES  NO

B. IN SKY DIVING, UNDERWATER DIVING, PARACHUTING, PARASAILING, ORGANIZED RACING OF ANY VEHICLE, ROCK AND/OR MOUNTAIN CLIMBING, BOXING, KAYAK COMPETITION, CAVE EXPLORATION, ICE BOATING, ICE CLIMBING, BALLOONING,

HELICOPTER, SKIING, OR CONTACT SPORTS ACTIVITIES?  YES  NO

*This section must be completed for all applications.*

1. a) Proposed Insured: Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. \_\_\_\_\_ Weight loss in past year(lbs)

b) Do you have a personal doctor?  YES  NO (If yes, write name, address, and telephone number below.)

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip Code

c) When was last visit and why? \_\_\_\_\_

**Please answer all questions.** (To provide us with additional information. Please use Medical Details section below.)

2. Has the proposed Insured had, been treated for, or been told by a doctor as having:

(Circle conditions to which Yes applies and give details in the Medical Details Section below.)



	Proposed Insured	Children
a) Convulsions, epilepsy, paralysis, mental, or nervous disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Asthma, emphysema, bronchitis, tuberculosis, sleep apnea, or other disorder of lung or respiratory system?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
d) Intestinal bleeding, chronic colitis, hepatitis, or other disorder of esophagus, stomach, intestines, liver, or pancreas?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
e) Diabetes, anemia or any disorder of glandular system or blood?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
f) Disease of kidney or bladder – or sugar, blood, or protein in urine?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
g) Arthritis or any disorder of muscles or bones including spine or joints?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
h) Cancer or tumor (any location)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
i) Any disorder of prostate or reproductive organs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
j) Any other medical condition not mentioned above?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

3. Has the proposed Insured:

*(Circle conditions to which Yes applies and give details in the Medical Details Section below.)*

	Proposed Insured	Children
a) Other than above, had examination, testing, treatment, or consultation with a doctor or been hospitalized during the past five years?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Been on, or are now on, any medication or prescribed diet?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Sought, or advised to seek treatment or advice, or been convicted for the use of drugs or alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
d) In the last five years used narcotics, hallucinogens, barbiturates, heroin, marijuana, cocaine, or any other drug not prescribed by a physician?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO



e) Ever been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)?  YES  NO  YES  NO

f) Ever received disability benefits?  YES  NO  YES  NO

g) Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed?  YES  NO  YES  NO

h) Had a parent, brother, or sister who had cancer, diabetes, or heart disease?  YES  NO  YES  NO

*(Please show age at onset and/or date of death.)*

i) In the last year, had any persistent symptoms, conditions, or disorders not listed above?  YES  NO  YES  NO

**NOTICE – ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.**

<b>Medical Details:</b>					Name, Address, and Telephone No.	
Person's Name	Question Number	Date of Onset	Diagnosis and Treatment	Duration	Attending Doctor and Hospital (if applicable)	Date Last Seen



USFL  
PO Box 3016  
Monroe, WI 53566-3016  
Phone: 800-959-3894  
Fax: (803)-233-3725

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

I hereby authorize any physician, medical professional, hospital, clinic, medical care institution, insurance company, Medical Information Bureau, consumer reporting agency, or employer that has any record or knowledge of me or my minor children of our physical or mental health, medical care, treatment or advice, employment information or other insurance coverage to give any such information to the company indicated above or its reinsurers. All such sources, except the Medical Information Bureau, may give such information to any agency employed by the company to collect and transmit information. I also authorize the company listed above or its reinsurers to release any health or personal information regarding me or my minor children to the Medical Information Bureau and to other life insurance companies in which I may have policies or to whom I may apply.

I understand this information will be used to evaluate my (our) application for life insurance and that I have a right to receive a copy of this authorization upon request. I agree this authorization is valid for thirty months from the date signed and that a photographic copy of the authorization is a valid as the original.

Dated at _____	Signature _____	
City	State	Primary proposed insured
(or if below age 15, parent or legal guardian must sign)		
Date _____	_____	
	Signature of Witness	Signature of Owner

**COMPLETE AND MAIL THIS FORM TO:**

USFL  
PO BOX 3016  
MONROE, WI 53566-3016