

# U.S. FINANCIAL LIFE INSURANCE COMPANY

## REQUEST FOR POLICY REINSTATEMENT FOR POLICY #

POLICY OWNER _____	INSURED _____
	HEIGHT _____ WEIGHT _____
	DATE OF BIRTH _____
	SOCIAL SECURITY NO. _____
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.**

	YES	NO
1. HAVE YOU USED TOBACCO IN ANY FORM IN THE PAST 12 MONTHS?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
B. IN SKY DIVING, PARACHUTING, HANG GLIDING, AUTO RACING OR ANY OTHER HAZARDOUS SPORTS?	<input type="checkbox"/>	<input type="checkbox"/>

*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 \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

**Please answer all questions.** *(To provide us with additional information, please use Medical Details section on page 2.)*

	Proposed Insured		Children	
	Yes	No	Yes	No
2) Has the Proposed Insured had, been treated for, or been told by a doctor as having: <i>(Circle conditions to which Yes applies and give details in the Medical Details section on page 2.)</i> .....				
a) Convulsions, epilepsy, paralysis, mental, or nervous disorders?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Asthma, emphysema, bronchitis, tuberculosis, sleep apnea, or other disorder of lung or respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Intestinal bleeding, chronic colitis, hepatitis, or other disorder of esophagus, stomach, intestines, liver, or pancreas?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Diabetes, anemia, or any disorder of glandular system or blood?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Disease of kidney or bladder—or sugar, blood or protein in urine?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Arthritis or any disorder of muscles or bones including spine or joints? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Cancer or tumor (any location)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Any disorder of prostate or reproductive organs? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Any other medical condition not mentioned above?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

