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?	☐	☐
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?	☐	☐
B. IN SKY DIVING, PARACHUTING, HANG GLIDING, AUTO RACING OR ANY OTHER HAZARDOUS SPORTS?	☐	☐

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.)*

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 on page 2.)*	Proposed Insured *Yes*	Proposed Insured *No*	Children *Yes*	Children *No*
a) Convulsions, epilepsy, paralysis, mental, or nervous disorders?	☐	☐	☐	☐
b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?	☐	☐	☐	☐
c) Asthma, emphysema, bronchitis, tuberculosis, sleep apnea, or other disorder of lung or respiratory system?	☐	☐	☐	☐
d) Intestinal bleeding, chronic colitis, hepatitis, or other disorder of esophagus, stomach, intestines, liver, or pancreas?	☐	☐	☐	☐
e) Diabetes, anemia, or any disorder of glandular system or blood?	☐	☐	☐	☐
f) Disease of kidney or bladder—or sugar, blood or protein in urine?	☐	☐	☐	☐
g) Arthritis or any disorder of muscles or bones including spine or joints?	☐	☐	☐	☐
h) Cancer or tumor (any location)?	☐	☐	☐	☐
i) Any disorder of prostate or reproductive organs?	☐	☐	☐	☐
j) Any other medical condition not mentioned above?	☐	☐	☐	☐

OK REINSTATEMENT1 (10/15)

3) Has the Proposed Insured: *(Circle conditions to which Yes applies and give details in the Medical Details section below.)*	Proposed Insured *Yes*	Proposed Insured *No*	Children *Yes*	Children *No*
a) Other than above, had examination, testing, treatment, or consultation with a doctor, or been hospitalized during the past five years?	☐	☐	☐	☐
b) Been on, or are now on, any medication or prescribed diet?	☐	☐	☐	☐
c) Sought, or advised to seek treatment or advice, or been convicted for the use of drugs or alcohol?	☐	☐	☐	☐
d) Ever used narcotics, hallucinogens, barbiturates, heroin, marijuana, cocaine, or any other drug not prescribed by a physician?	☐	☐	☐	☐
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)?	☐	☐	☐	☐
f) Ever received disability benefits?	☐	☐	☐	☐
g) Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed?	☐	☐	☐	☐
h) Had a parent, brother, or sister who had cancer, diabetes or heart disease? *(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?	☐	☐	☐	☐

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF ANY INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

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

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 as valid as the original.

Dated at _____ _____
city state signature of primary proposed insured (or if below age 15, parent or legal guardian must sign)

Date _____ _____ _____
signature of witness signature of owner

FOR OFFICE USE ONLY
REINSTATEMENT APPROVED: _____
ON: _____
BY: _____

COMPLETE AND MAIL THIS FORM TO:
USFL
PO BOX 1419
Charlotte NC 28201-1419