

# 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:<br><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"/> |

WY REINSTATEMENT1 (10/15)

| 3) Has the Proposed Insured:<br>(Circle conditions to which Yes applies and give details in the Medical Details section below.)                                                                                                | Proposed Insured         |                          | Children                 |                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                                                                                                                                                                                                                                | Yes                      | No                       | Yes                      | No                       |
| a) Other than above, had examination, testing, treatment, or consultation with a doctor, or been hospitalized during the past five years? .....                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Been on, or are now on, any medication or prescribed diet? .....                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Sought, or advised to seek treatment or advice, or been convicted for the use of drugs or alcohol?.....                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Ever used narcotics, hallucinogens, barbiturates, heroin, marijuana, cocaine, or any other drug not prescribed by a physician? .....                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)? ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Ever received disability benefits? .....                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed? .....                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Had a parent, brother, or sister who had cancer, diabetes or heart disease?.....<br>(Please show age at onset and/or date of death.)                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) In the last year, had any persistent symptoms, conditions, or disorders not listed above? .....                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NOTE-ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

| 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<br>(or if below age 15, parent or legal guardian must sign) |       |
| Date _____           | _____ | _____                                                                                             | _____ |
| signature of witness |       | signature of owner                                                                                |       |

|                                                                                                   |
|---------------------------------------------------------------------------------------------------|
| <p>FOR OFFICE USE ONLY</p> <p>REINSTATEMENT APPROVED: _____</p> <p>ON: _____</p> <p>BY: _____</p> |
|---------------------------------------------------------------------------------------------------|

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