Lincoln Heritage® LIFE INSURANCE COMPANY

Executive Offices:
4343 East Camelback Road, Suite 400
Phoenix, AZ 85018-2705
Fax: (602) 808-0521
Email: service@lhlic.com
Policy Portal: service.lhlic.com

APPLICATION FOR REINSTATEMENT

Please Print Legibly

REDATE | **Policy #**

INSURED INFORMATION

First Name | M.I. | Last Name

Social Security # - -

Secondary Addressee (Name, Address and Phone Number)

First Name | M.I. | Last Name | Phone# - -

Address | Apt. # | City | State | Zip

I understand that said policy will not be reinstated until this application has been approved and the necessary premium has been received by the Home Office. The following representations may be used as a basis for contestability of a claim for not more than two (2) years after the date of such representation.

All applicants must permanently reside in the United States.

1. Is any proposed insured bedridden, incarcerated, in a care facility, receiving hospice care, or has ever been diagnosed by a physician as having a terminal illness? ☐ Yes ☐ No
2. Has any proposed insured been hospitalized in the past ninety (90) days? ☐ Yes ☐ No
3. In the past two (2) years, has any proposed insured been diagnosed with, been treated by a member of the medical profession, or taken medication for any of the following conditions:
   a. A disease of the heart, lungs, liver, kidney, circulatory or immune system (except for previous HIV tests), or with any form of internal cancer, or used oxygen to assist in breathing? ☐ Yes ☐ No
   b. Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   c. Alcohol or drug abuse? ☐ Yes ☐ No

If "yes" to any question, please explain:

I authorize any pharmacy or pharmacy benefit manager that possesses prescription history about me to furnish such health information to Lincoln Heritage Life Insurance Company or its reinsurers for the purpose of evaluating my application for insurance. Health information obtained will not be redisclosed without my authorization unless permitted by law, in which case, it may not be protected under federal privacy rules. This authorization shall be valid for two (2) years from this date and may be revoked by sending written notice to Lincoln Heritage Life Insurance Company. You, a person authorized to act on your behalf or your authorized representative are entitled to receive a copy of the authorization form.

If you do not sign this application Lincoln Heritage Life Insurance Company will not be able to process the reinstatement of your coverage and it may be a basis for denying this reinstatement application.

Visit lhlic.com for information regarding our data collection and privacy information.

For your protection California Law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the Company will rely on my answers in issuing the insurance.

If previously on Automatic Payment Plan, do you wish to resume? ☐ Yes ☐ No

Draft my account/card on file for reinstatement/redate payment: As soon as possible upon receipt at Home Office

On or after - - 20

Signature of Owner | Date - - 20

Signature of Insured(s) If eighteen (18) years or older | Date - - 20

FOR PRODUCER USE ONLY

I confirm that the Owner and Insured(s) answered and completed this application for reinstatement of the policy listed.

Signature of Producer | Producer's Number -