GUARANTY
INCOME LIFE INSURANCE COMPANY

929 Government St., Baton Rouge, LA 70802
P.O. Box 2231, Baton Rouge, LA 70821-2231
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APPLICATION FOR REINSTATEMENT

INSTRUCTIONS

Section 1 may be used if policy has been lapsed less than 90 days and applicant is in good health, without any serious illnesses or bodily injury within the last five (5) years. If lapsed more than 90 days, Section 2 must be completed. Section 2 may also be used for adding a waiver benefit or a rider.

POLICY NO._____ INSURED _____ OWNER _____.
AMOUNT OF PREMIUM $_____ AMOUNT ENCLOSED $_____ PREMIUM DUE DATE _____.

SECTION 1

I hereby request reinstatement of the above policy in accordance with the policy provisions. I represent that, to the best of my knowledge and belief, all persons covered under this policy are now in good health; have not suffered any serious illness or bodily injury nor received treatment from any physician within the past five (5) years.

_____ _____
Witness **Insured**

SECTION 2

Date of Relationship ☐ Male Ht.____

1. Applicant_____Birth_____to Insured_____ ☐ Female Wt.____
   Present Date
2. Occupation_____ Employed_____Has any application for life insurance been declined, postponed or modified? ☐ Yes ☐ No If yes, give reason_____

NON-MEDICAL DECLARATIONS

(Following questions apply to all persons covered under this contract)

		Yes	No
3.	Has any insured ever had or been told they had:		
	(a) Disorder of eyes, ears, nose or throat?	☐	☐
	(b) Diabetes, Thyroid Disease or Enlarged Glands?	☐	☐
	(c) Tumor, Polyp, Cyst, Cancer or Skin Disease?	☐	☐
	(d) Pain, Pressure or discomfort in the chest, undue shortness of breath or Angina?	☐	☐
	(e) High Blood Pressure, palpitation, swelling of the feet or ankles?	☐	☐
	(f) Rheumatic Fever or heart murmur?	☐	☐
	(g) Heart attack, stroke, myocardial infarction, heart or coronary disease?	☐	☐
	(h) Recurrent indigestion, ulcer, colitis or gall bladder disorder?	☐	☐
	(i) Hepatitis, jaundice, liver or pancreas disorder?	☐	☐
	(j) Pneumonia, pleurisy, asthma, tuberculosis, chronic cough, emphysema?	☐	☐
	(k) Fainting spells, concussion, skull fracture, severe headaches, dizziness or convulsions?	☐	☐
	(l) Epilepsy, paralysis or mental disorders?	☐	☐
	(m) Kidney disease, kidney stone, nephritis, bladder or prostate disorder?	☐	☐
	(n) Albumin, sugar, pus or blood in the urine?	☐	☐
	(o) Gout, Arthritis or any other disorder of bone or joints?	☐	☐
	(p) Anemia or any other blood disorder?	☐	☐
	(q) An immune deficiency disorder, AIDS, the AIDS related complex (ARC) or test results indicating exposure to the AIDS virus?	☐	☐
4.	Is any insured now taking medication prescribed by a physician?	☐	☐
5.	Except as prescribed by a physician, has any insured ever used:		
	(a) Heroin, Morphine, Cocaine, Opiates or Barbiturates?	☐	☐
	(b) Marijuana, Quaalude, Amphetamines, Depressants, Sedatives, Tranquilizers or Hallucinogens?	☐	☐
6.	Has any insured ever been treated for drug or alcohol usage?	☐	☐
7.	Has any insured been advised to have or had any surgical operation, x-ray treatment, blood test, thyroid test, electrocardiogram or x-ray?	☐	☐
8.	If Applicable:		
	(a) Has any insured ever miscarried or had any disease or tumor of the uterus, ovaries, tubes or breast or any other reproductive disorder?	☐	☐
	(b) Is any insured now pregnant?	☐	☐
9.	Has any insured consulted or been treated for any condition not listed above by any physician or practitioner within the past five (5) years?	☐	☐

Describe history of any "Yes" answers above. Give illness, duration, results and name and address of attending physician, hospital or clinic. Use additional sheet, if necessary.

I hereby represent that the above information, to the best of my knowledge and belief, is complete and true and I agree the Company shall consider it the basis of any action. It is understood, however, that the Company has the right to require a medical examination and agree that no reinstatement of said policy shall be effective unless the evidence of my insurability based on the above answers are satisfactory to the Company and the application has been approved by the Company and all sums required for reinstatement shall have been paid. It is also agreed that the reinstatement of this policy shall be subject to the Incontestable Provisions contained in the original policy. Any licensed physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of my or my health is authorized and directed to give any and all information to Guaranty Income Life Insurance Company. A photocopy of this authorization is as valid as the original.

DATED AT_____THIS_____DAY OF_____, _____.
City and State

_____
Signature of Insured (Parent, if juvenile)

_____
Witness

_____
Signature of Owner, if other than Insured