U.S. FINANCIAL LIFE INSURANCE COMPANY REQUEST FOR POLICY REINSTATEMENT FOR POLICY

POLICY OWNER	INSURED				
	HEIGHT				
	DATE OF BIRTH	_			_
	SOCIAL SECURITY NO				_
HOME PHONE	WORK PHONE				_
PLEASE NOTE ANY CHANGE O	F ADDRESS ABOVE				
IMPORTANT: ANSWER ALL THE QUESTIONS BELOW AND SIG "YES" ANSWERS IN THE SPACE PROVIDED. ATTACH AN ADDI			TAILS	S TO ANY	
 HAVE YOU USED TOBACCO IN ANY FORM IN THE PAST 12 MC HAVE YOU EVER OR DO YOU ANTICIPATE IN THE NEXT TWO PARTICIPATION: 			YES D	NO □	
A. AS A PILOT OR MEMBER OF THE CREW OF ANY TY B. IN SKY DIVING, PARACHUTING, HANG GLIDING, AU					
ANY OTHER HAZARDOUS SPORTS?					
 This section must be completed for all applications. 1) a) Proposed Insured: Height ft ft in. Weigh b) Do you have a personal doctor? □ Yes □ No (If Yes, write name) 			oss in	past year (lb	os.)
Name					
Address	Telephone				
City	State	Zip			
-		-			
c) When was last visit and why?			<u>,</u>		
Please answer all questions. (To provide us with additional information, plea	ise use Medical Details section) oosed		
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 sector	on on page 2.)	Insu	red	Childre Yes N	
a) Convulsions, epilepsy, paralysis, mental, or nervous disorders?		🛛			
b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disc	order of the heart or circulatory sys	stem? 🛛			
c) Asthma, emphysema, bronchitis, tuberculosis, sleep apnea, or other disorder of l	ung or respiratory system?	🛛			
d) Intestinal bleeding, chronic colitis, hepatitis, or other disorder of esophagus, stor	mach, intestines, liver, or pancreas	s? 🗖			
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?		🛛			

3)	Has the Proposed Insured: (Circle conditions to which Yes applies and give details in the Medical Details section below.)	Propo Insur Yes	Child Yes	
	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?			
	i) In the last year, had any persistent symptoms, conditions, or disorders not listed above?			

NOTICE - ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Medical Details:						
		Date	Diagnosis		Name, Address, and Telephone No.	Date
	Question	of	and		Attending Doctor and Hospital	Last
Person's Name	Number	Onset	Treatment	Duration	(if applicable)	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
REINSTATEMENT A ON: BY:	FOR OFFICE USE ONLY		COMPLETE AND MAIL THIS FORM TO: USFL PO BOX 1419 Charlotte NC 28201-1419