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 O	F ADDRESS ABOVE				
IMPORTANT ANOMER ALL THE QUESTIONS RELOW AND OU	NA ON THE BOTTOM BBOX	"55 55			
IMPORTANT: ANSWER ALL THE QUESTIONS BELOW AND SIG "YES" ANSWERS IN THE SPACE PROVIDED. ATTACH AN ADDI			AILS	IO AN	Y
TEO ANOWERO IN THE OFACE PROVIDED. AFRACITAN ADDI	HONAL GHEET II NEOLOG		YES	NO	
1. HAVE YOU USED TOBACCO IN ANY FORM IN THE PAST 12 MG	ONTHS?				
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 TY	PE OF AIRCRAFT?				
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 in. Weig	ht lbs	_Weight lo	ss in p	ast year	(lbs.)
b) Do you have a personal doctor? Yes No (If Yes, write name)	e, address, and telephone numbe	r 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		on page 2.)			
· · ·		Prop	osed		
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 sect.	ion on page 2)	Insui <i>Yes</i>	red <i>No</i>	Chile <i>Yes</i>	dren <i>No</i>
a) Convulsions, epilepsy, paralysis, mental, or nervous disorders?					
b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other dis					
c) Asthma, emphysema, bronchitis, tuberculosis, sleep apnea, or other disorder of					
d) Intestinal bleeding, chronic colitis, hepatitis, or other disorder of esophagus, sto					
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?					
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VT REINSTATEMENT1 (10/15)

3) Has the Proposed Insured: (Circle conditions to which Yes applies of	and give details:	n the Medies	l Dotails section	n halow)		Prop Insui		Chilo Yes	
a) Other than above, had examination, t	esting, treatment	, or consultat	ion with a doct	or, or been			100	ies	100
hospitalized during the past five year									
b) Been on, or are now on, any medicat	-								
c) Sought, or advised to seek treatment						🗆			
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 (AID: Human Immunodeficiency Virus (HI	S), AIDS Related	l Complex (A	RC), or tested	positive for		. 🗆			
f) Ever received disability benefits?						🗆			
g) Been advised to have any diagnostic disorders related to HIV antibody, T-	test, hospitalizat	ion, or surger	y which has no	t been complete	ed (except for				
h) Had a parent, brother, or sister who had cancer, diabetes or heart disease?					. 🗆				
i) In the last year, had any persistent syr	nptoms, conditio	ons, or disorde	ers not listed ab	ove?		🗆			
NOTICE - ANY PERSON WHO, WITH INTEN APPLICATION OR FILES A CLAIM CONTAI						NSURI	ER, SUBM	IITS AN	
Medical Details: Person's Name	Question Number			Duration	Name, Address, and Attending Doctor a	r and Hospital		Date Last Seen	
	AUTHODIZ	ATION TO	DELEAGEM	EDICAL REC	CORDS				
I hereby authorize any physician, medi Bureau, consumer reporting agency, or health, medical care, treatment or advicindicated above or its reinsurers. All su employed by the company to collect ar health or personal information regarding in which I may have policies or to who I understand this information will be us this authorization upon request. I agree authorization is as valid as the original. This authorization to release this information will be used to be a support of the s	employer that ce, employmen ich sources, exo nd transmit info ing me or my mi om I may apply sed to evaluate this authorizat	has any reco t informatio cept the Mecormation. I a inor children my (our) ap tion is valid	ord or knowle on or other insidical Informatilso authorize in to the Medical opplication for 1 for 24 months	dge of me or rurance coveragion Bureau, methe company leal Information difference as from the date	my minor children of ge to give any such in lay give such informal isted above or its rein Bureau and to other and that I have a right e signed and that a photo previously administ	our ph forma tion to surers life in to recotogra	tion to to any ago to releasurance eeive a cophic coptest for I	r menta he com- ency se any compa opy of by of th	il pany nies
antibodies, T-cell counts, AIDS or ARC physician, health care professional, hos reporting agency, other insurance comp	spital, clinic, m	edical facili	ty, U.S. Veter	ans Administra	ation, the MIB, Inc.,				
Dated at									
city	state	2			ature of primary propage 15, parent or lega			st sign)	
Date	signature	of witness			signature of own	er			
FOR OFFICE USE ONLY		 1							
REINSTATEMENT APPROVED:ON:BY:			USFL PO BO	OX 1419 otte NC 28201-	AIL THIS FORM TO:				