



Application for Reinstatement

I/We hereby make application to Memorial Service Life Insurance Company for reinstatement of Policy No. _____, heretofore issued, and agree to pay all past due premium payments in the amount of \$ _____, covering the period from _____ to _____.

1. Are all insured covered under this policy in good health? Yes ___ No ___
if No, give complete details: _____

2. Has any insured covered under this policy **EVER** been treated for Cancer ___ Heart
Trouble ___ Diabetes ___ or AIDS ___?
If Yes, give doctor's name and address: _____

It is agreed and understood that the Company may NOT be liable for any benefits to any individual insured or beneficiary under the above numbered policy contract during a new contestable period of twenty-four (24) months from date hereof, except the refund of all premiums paid for any such insured, should any insured listed hereon be found in ill health or have impaired physical condition at the time of making application for reinstatement of the policy. Any misstatement as to health or physical condition contained herein must be made material and made with the intent to deceive said Company in order to avoid the reinstatement.

I/We further agree that this application for reinstatement shall not become effective until written notice of approval has been given by an officer of the company.

Review Your answers! Make sure all questions are answered correctly!

Insured/Policy owner

Date

Witness