

**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 OF ADDRESS ABOVE	

**IMPORTANT: ANSWER ALL THE QUESTIONS BELOW AND SIGN ON THE BOTTOM. PROVIDE DETAILS TO ANY "YES" ANSWERS IN THE SPACE PROVIDED. ATTACH AN ADDITIONAL SHEET IF NECESSARY.**

	YES	NO
1. HAVE YOU USED TOBACCO IN ANY FORM IN THE PAST 12 MONTHS?	<input type="checkbox"/>	<input type="checkbox"/>
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 TYPE OF AIRCRAFT?	<input type="checkbox"/>	<input type="checkbox"/>
B. IN SKY DIVING, PARACHUTING, HANG GLIDING, AUTO RACING OR ANY OTHER HAZARDOUS SPORTS?	<input type="checkbox"/>	<input type="checkbox"/>

*This section must be completed for all applications.*

1) a) Proposed Insured:    Height            ft.            in.            Weight            lbs.            Weight loss in past year (lbs.)

          b) Do you have a personal doctor?            Yes    No *(If Yes, write name, address, and telephone number 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 use Part II Special Requests and Remarks section.)**

	Proposed Insured		Children	
	Yes	No	Yes	No
2) Has the Proposed Insured had, been treated for, or been told by a doctor as having: <i>(Circle conditions to which Yes applies and give details in the Medical Details section on page 2).....</i>				
a) Convulsions, epilepsy, paralysis, mental, or nervous disorders?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Chest pain, high blood pressure, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Asthma, emphysema, bronchitis, tuberculosis, sleep apnea, or other disorder of lung or respiratory system?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Intestinal bleeding, chronic colitis, hepatitis, or other disorder of esophagus, stomach, intestines, liver, or pancreas?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Diabetes, anemia, or any disorder of glandular system or blood? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Disease of kidney or bladder—or sugar, blood or protein in urine? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Arthritis or any disorder of muscles or bones including spine or joints? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Cancer or tumor (any location)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Any disorder of prostate or reproductive organs? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Any other medical condition not mentioned above?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CT REINSTATEMENT1 (11/09)





**Financial Supplement II Forming Part of the Application for Life Insurance** (Complete if the Proposed Insured is age 65 or older and the sum of the Face Amount of all applications for life insurance that will be underwritten concurrently with AXA Equitable, and/or any other affiliated company, equals \$2 million or more.) If additional space is needed to complete this application, attach additional sheet of paper; it must be signed and dated by the Proposed Owner, Proposed Insured, and Financial Professional.

\_\_\_\_\_  
Name  Proposed Insured/  Additional/Joint Insured

\_\_\_\_\_  
Owner name if other than Proposed/Additional Insured

1. What is the planned source of funding for the policy(ies) currently applied for? (Please provide details of funding, including name(s) of all entities involved. If the source of funding is from a life insurance policy, include the name of each company and number of years policy in effect.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Has any party, other than the Proposed Owner or Proposed Insured, provided or offered to provide funding, either now or in the future, for any premium payment for the policy? (If "Yes", please provide details of the funding, including the names of all entities involved.) \_\_\_\_\_  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

3 a. Are either the Proposed Owner or Proposed Insured now financing or intending to finance any of the premium payments required to pay for and/or to maintain this policy through a financing or loan agreement? (If "Yes", submit a copy of the financing or loan agreement, detailed Personal Financial Statement signed by the preparer, and complete below.)  Yes  No

Loan \_\_\_\_\_ (% of premium) Identify Source of Loan \_\_\_\_\_

Loan Repayment Schedule (If the loan can be extended, include duration for which loan may be extended) \_\_\_\_\_

Describe the collateral used \_\_\_\_\_

b. Is the Proposed Owner or Proposed Insured required to post a letter of credit or personal guarantee?  Yes  No  
(If "Yes", please describe details of asset(s) or financial institution offering the guarantee.)

Interest rate \_\_\_\_\_ % Frequency \_\_\_\_\_ Duration \_\_\_\_\_

c. If interest may be accrued, give details \_\_\_\_\_

d. In addition to repayment of principal and interest, are there other fees, charges, or other consideration to be paid on maturity?  Yes  No  
(If "Yes", give details of additional fees, charges, or consideration) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Other Financing Agreement

If the Proposed Owner or Proposed Insured will be paying premiums funded by an individual and/or an entity other than the Proposed Insured(s), or the Proposed Insured's employer, provide details of the arrangement together with any documents relating to the arrangement:

Description \_\_\_\_\_ Interest rate \_\_\_\_\_ % Frequency \_\_\_\_\_ Duration \_\_\_\_\_

Additional fees, charges, or consideration \_\_\_\_\_

5. Are the Proposed Owner, Proposed Insured, or any person or entity, either being paid or offered: cash, services, or any other consideration, as an inducement (a) to enter into this transaction or (b) for the transfer of any beneficial interest in the proceeds of the policy? (If "Yes", describe in detail.) \_\_\_\_\_  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

6. Will any entity, other than a life insurance company, be medically evaluating the Proposed Insured to determine life expectancy, or otherwise provide financing? (If "Yes", give details, including the name(s) of the entity(ies)) \_\_\_\_\_  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

**References (Personal and/or Business)**

Attorney:	_____	_____	_____
	Name	Business Address	Telephone No.
Accountant:	_____	_____	_____
	Name	Business Address	Telephone No.
Other:	_____	_____	_____
	Name	Branch	Title of Account
	_____	_____	_____
	Name	Branch	Title of Account
Have bankers, attorneys and accountants been authorized to release information?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If "no", explain _____			
I represent that the statements and answers in this Supplement, and in any supporting documentation provided by me for use in conjunction with this Supplement, are true and complete to the best of my knowledge and belief.			
Signature of Proposed Insured/Additional Joint Insured _____		Date _____	
Signature of Owner if other than Insured _____			
Signature of Licensed Financial Professional/Insurance Broker _____			