

**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, UNDERWATER DIVING, PARACHUTING, PARASAILING, ORGANIZED RACING OF ANY VEHICLE, ROCK AND/OR MOUNTAIN CLIMBING, BOXING, KAYAK COMPETITION, CAVE EXPLORATION, ICE BOATING, ICE CLIMBING, BALLOONING, HELICOPTER, SKIING, OR CONTACT SPORTS ACTIVITIES?	<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 Medical Details section on page 2.)*

	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"/>

MN REINSTATEMENT1 (12/06)

References (Personal and/or Business)

Attorney:	_____	_____	_____
	Name	Business Address	Telephone
Accountant:	_____	_____	_____
	Name	Business Address	Telephone
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			