HERMANN SONS LIFE

Application for Reinstatement

Certificate No: ____________

INSURED INFORMATION

PLEASE PRINT IN BLUE OR BLACK INK ONLY

FULL NAME: FIRST ______ MIDDLE ______ LAST ______ SUFFIX ______

DATE OF BIRTH: MM/DD/YYYY

MAILING ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

SOCIAL SECURITY NO.: XXX-XX-XXXX

EMAIL ADDRESS ______ AGE ______ SEX ______

MARITAL STATUS: ☐ Married ☐ Widowed ☐ Single ☐ Divorced

CELL PHONE NO.: XXX-XXX-XXXX

WORK PHONE NO.: XXX-XXX-XXXX

OCCUPATION/JOB DESCRIPTION ______

INSURED MEDICAL INFORMATION

Question	YES	NO
1. (a) Exact Height ____ ft. ____ in. (b) Weight ____ lbs.		
2. Have you gained or lost weight within the last two years?.......... ☐ Gained ☐Lost (If "YES", give amount and reason.)	☐	☐
3. Do you currently or have you ever used tobacco, nicotine or vape products? .... If "YES," give type, amount and dates used.	☐	☐
4. Have you ever had a life insurance application declined, postponed, rated, modified, or withdrawn? .... If "YES", give name of company(ies), date and reason.	☐	☐
5. Have you ever had your driver's license suspended or revoked; or ever been convicted of DWI or DUI; or in the past 3 years been convicted of more than one moving violation?............................ If "YES," please provide driver's license number and details.	☐	☐
6. Except as prescribed by a physician, have you ever used, or been convicted for the sale or possession of cocaine or any other narcotic or illegal drug?...	☐	☐
7. Have you ever been treated for, received counseling, been advised to seek counseling, or joined a support organization because of ALCOHOL or DRUG usage?....................................	☐	☐
8. Have your PARENTS, BROTHERS or SISTERS ever had diabetes,cancer, high blood pressure, heart disease or a congenital disorder? .... If "YES", give relationship, condition, age at diagnosis and current age or age at time of death.	☐	☐
9. Have you ever been treated or evaluated at a hospital, clinic or other facility, or been advised to have any test or surgery not yet completed? (If "YES", explain.)	☐	☐

Question	YES	NO
10. Have you had or been told you had AIDS,AIDS Related Complex or AIDS related symptoms? Or have you ever tested positive for antibodies to the AIDS (Human T-cell Lymphotropic Type III; HTLV-III)?	☐	☐
11. Have you received treatment by a member of the medical profession in connection with any of the categories mentioned in #10?..	☐	☐
12. To the best of your knowledge and belief, in the past 10 years, have you been medically treated for, or been diagnosed as having:		
a) Any disorder of the heart, circulatory, blood or immune system? (Examples include chest pain, heart murmur, heart attack, abnormal heart beat, high blood pressure, varicose veins, shortness of breath, disorder of blood vessels, anemia, stroke, transient ischemic attack (TIA), etc.)	☐	☐
b) Cancer, tumor, cyst, growth or enlargement of the lymph gland?..	☐	☐
c) Any disorder of the Respiratory System? (Examples include Allergies, Asthma, Bronchitis, Emphysema, Tuberculosis, Reactive Airway Disease, or other lung disorders.)	☐	☐
d) Any disorder of the digestive system, such as disease of the stomach, intestines, rectum, liver, gallbladder, esophagus, diarrhea of more than one week's duration, ulcer, hermorrhoids, polyps or hernia, etc.?	☐	☐
e) Any disorder of the urinary system? (Examples include references to the urinary organs or functions such as albumin, blood, sugar or pus in the urine; diseases of the kidney, bladder, etc.?)..	☐	☐
f) Diabetes, abnormal blood sugar, thyroid, adrenal, parathyroid, pituitary or other glandular disorders.	☐	☐
g) Depression, anxiety, bipolar disorder, obsessive compulsive disorder, neurosis, psychosis, schizophrenia, attention deficit disorder (ADD/ADHD), affective disorders, eating disorder,hallucinations or any other mental behavioral, psychological,or psychiatric disorders?.................................	☐	☐
h) Any disorder of the nervous system, such as epilepsy, convulsions, loss of consciousness, dizziness, paralysis, headaches, nervousness, mental disorder, or received psychiatric treatment or attempted suicide, etc.?	☐	☐
i) Any disorder of the muscles, skin or bone? (Examples include gout, arthritis, collagen disease (connective tissue disease),disorders of the back, joints, extremities, muscles, etc.; orreceived chiropractic or therapist consultation.)	☐	☐
j) Any disorder or the male or female reproductive organs? (Examples depending on gender include menstrual disorder, complications of pregnancy, Caesarean section, or prostate disorder, etc.)..	☐	☐
k) Any disorder of eyes, ears, nose or throat? (Except for cataracts, not necessary to include vision corrected with glasses or contact lenses.)	☐	☐

Have you experienced any other changes diagnoses or treatments since the original application? (If yes, please provide detail below) ☐ Yes ☐ No

If you answered “yes” to any questions in the “Insured Medical Information” section, please provide details.

PLEASE INCLUDE ALL TESTS, DIAGNOSIS, DURATION, MEDICATION AND TREATMENTS						
TEST PERFORMED	DIAGNOSIS	DATE BEGAN MO/YR	DATE ENDED MO/YR	MEDICATIONS	TREATMENTS	FULL NAME, ADDRESS & PHONE NO. OF PHYSICIANS & HOSPITALS

INSURED PRIMARY CARE PHYSICIAN

NAME FIRST ______ LAST ______

ADDRESS ______

CITY ______ STATE ______ ZIP ______

PHONE NO. XXX-XXX-XXXX ______

INSURED LIFESTYLE & HAZARDOUS ACTIVITY INFORMATION

Have you been a pilot or student pilot, crew member or had any duties on board an aircraft in flight during the past 3 years? ☐ Yes ☐ No

Have you engaged in any hazardous sports, amusement or avocation activities during the past 3 years? Examples include Scuba Diving, Parachuting, Vehicle or Boat Racing, Ballooning or Hang Gliding. ☐ Yes ☐ No

Do you plan to travel or reside outside of the United States? If “Yes,” give reason, destination and length of stay: ☐ Yes ☐ No

The representations in this application are true to the best of your knowledge and belief. It is agreed that this certificate will not be reinstated and we will have no liability (other than to return payments made consequent to this application without interest) until: (1) all money required for reinstatement of this certificate has been paid; and (2) this application has been approved by us at our Home Office during the lifetime of the applicant who would be insured under this policy if reinstated.

It is agreed that the Date of Reinstatement will be as follows: (1) the date of approval by us of the Application for Reinstatement or (2) the first monthly anniversary day on or following the date of approval by us of the Application for Reinstatement.

It is further agreed that reinstatement of the certificate, if granted by us, will be contestable for fraud or misrepresentation of any material facts stated in, or in connection with, this application for two years after the Date of Reinstatement. All past due premiums must be paid.

If the member, whether sane or insane, dies by suicide or self-destruction within two years from the effective Date of Reinstatement, our liability will be limited to a refund of the amount equal to the premiums paid for this certificate since the effective Date of Reinstatement.

____ ____________________

SIGNATURE OF INSURED (Parent/Legal Guardian if under 18 years) DATE

____ ____________________

SIGNATURE OF CERTIFICATE OWNER(S) (If different from insured) DATE

OWNER(S) INFORMATION (IF DIFFERENT FROM INSURED)

Name ____

Address ____

City ____________________________ State ______________ Zip ______________

Phone No. ____

______________________________ ______________________________

Home Office Approval Date

Please note: *"You" and "Your" refer to the applicant. "We," "Us" and "Our" refer to Hermann Sons Life.*