



# INVESTORS HERITAGE *Life Insurance Company*

P.O. Box 717  
 Frankfort, KY 40602-0717  
 1-800-422-2011  
 E-Mail: [Ihlic@ihlic.com](mailto:Ihlic@ihlic.com)  
 Web Site: [www.investorsheritage.com](http://www.investorsheritage.com)

Insured's Full Name: _____	Home Telephone Number: (    ) _____
Current Address: _____	
Policy Number(s): _____	Social Security No: _____

## APPLICATION FOR REINSTATEMENT

**INSTRUCTIONS: Complete separate reinstatement application for each covered person.**

To the best of your knowledge and belief, since the date of this policy:	IF ANSWERED "YES" GIVE DETAILS BELOW
1. Have you been diagnosed with any terminal illness? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Are you currently bedridden at home, confined in a hospital, nursing home, or long-term care facility or receiving Hospice care?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you had or been treated for, or are you taking medication for any of the following:	
a) Heart disease or disorder, heart attack, stroke, chest pain, heart surgery, angioplasty, high blood pressure, diabetes or congestive heart failure? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Cancer or melanoma, leukemia, kidney failure or dialysis, alcoholism, drug abuse, liver disease or cirrhosis, chronic lung disease, or tuberculosis?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Alzheimer's Disease, Parkinson's Disease, Down's Syndrome, Lou Gehrig's Disease (ALS), Multiple Sclerosis (MS), seizure disorder or any other disorder of the brain or nervous system?...	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. To the best of your knowledge, have you tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Been in a hospital, clinic, or institution for examination, observation, diagnosis, operation or treatment?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Consulted or been treated by any physician or practitioner or had any physical impairment, sickness, injury, surgery or mental disorder not mentioned above?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Had any life or health insurance declined, postponed, or rated or refused reinstatement or renewal?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Had two or more moving violations, or had a driver's license suspended or revoked within the past 5 years?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Driver's License Number _____ State of: _____	
10. Engaged in or expect to engage in aviation activities or hazardous sports, avocations or hobbies?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
11. Changed occupations? If yes, give present occupations and employers and duties below.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
12. Are you now a cigarette smoker?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. If "YES", number of packs daily? _____	
b. Have you ever been a cigarette smoker and quit?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. If "YES", when did you quit? Date (month/year) _____	
d. Do you use tobacco in any other form? If "YES", Type: _____ .....	<input type="checkbox"/> YES <input type="checkbox"/> NO
13. Height: _____ ft. and _____ inches      Weight: _____ lbs.	

GIVE COMPLETE DETAILS BELOW FOR ANY "YES" ANSWERS ABOVE:			
Question Number	Date(s)	Details Condition, operation performed, hospitalization, medications, other details	Names & addresses of doctors, hospitals or clinics involved

21001 FL (5-2001)

### NOTICE OF INFORMATION PRACTICES This Notice To Be Detached and Retained by Insured

**(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)**

In considering your application, information from various sources will be considered. These include your statements, the results of your physical examination (if required), and reports we get from doctors or medical facilities which have attended you.

Information about your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report of this to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon the receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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I (We) represent that all statements and answers in this application are full, complete and true to the best of my (our) knowledge and belief. I (we) understand that said statements and answers are submitted as evidence of insurability of each person insured under the policy. It is agreed that this policy will not be reinstated and the company will have no liability until (1) all money required for reinstatement of this policy has been paid; (2) this application has been approved by Investors Heritage Life Insurance Company Home Office during the lifetime of all persons who would be insured under this policy if reinstated. It is further agreed that with regard to the statements and answers provided above, any period of contestability provided in the policy shall run anew from the effective date of reinstatement.

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give Investors Heritage Life Insurance Company, or its reinsurer(s), any such information. A photographic copy of this authorization shall be as valid as the original.

This authorization shall be valid for 30 months from the date shown below. A photographic copy shall be as valid as the original. I have received a copy of the Notice of Information Practices.

**Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

DATE: \_\_\_\_\_  
Signature of Owner (Always Required)

WITNESS: \_\_\_\_\_  
Signature of Insured, if other than Owner  
(or Parent if insured is minor)

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**NOTICE OF INFORMATION PRACTICES continued**

We or our reinsurers, may also release information to other life insurance companies to whom you apply for life or health insurance, or to whom a claim is submitted.

In addition, we may get an investigative report from a consumer reporting agency. This report requires personal interviews with your neighbors, friends, or other acquaintances for information as to your general reputation, personal characteristics and mode of living. As part of your application, you have authorized us to do this. You have the right to be personally interviewed and to make a written request within a reasonable period about the nature and scope of this investigation. Upon written request you will be told if such a report has actually been ordered, and if it has, we will give you the name and address of the consumer reporting agency. You may contact this consumer reporting agency and ask for a copy of such report. Unless a legitimate business need exists or we are required to do so by law, the information we get in this report, as well as any other information which we later acquire, will not be disclosed to anyone else without your consent. You may request a copy of all information acquired by us and have a right to correct any personal information which you feel is inaccurate. We will, if required by law, give you a more detailed notice of the types of personal information which we get in considering your application, as well as any additional rights which you may have.

If you need any assistance, please feel free to contact your agent or call or write to us at Investors Heritage Life Insurance Company, Underwriting Department, 200 Capital Avenue, PO Box 717, Frankfort, Kentucky 40602-0717.