❑ **Central Security Life Insurance Company**
❑ **Western American Life Insurance Company**
❑ _____**Life Insurance Company**

Post Office Box 833879
Richardson, TX 75083-3879
972-699-2770

Application for Reinstatement

Policy # _____

Principal Insured | Date of Birth | Attained Age

Street Address | Phone Number

City/State/ZIP | Social Security Number

	No	Yes
1. Has any person covered by this policy smoked tobacco or used tobacco in any form in the past 12 months?	❑	❑
2. Is any person covered by this policy now pregnant?	❑	❑
Any miscarriages or complications of pregnancy?	❑	❑
3. Has any person covered by this policy ever:		
A. Been convicted of a felony?	❑	❑
B. Been arrested for driving while intoxicated, had a driver's license suspended or revoked or had a moving violation in the last three years?	❑	❑
4. Has any person covered by this policy:		
A. Made or intend to make any flights as a pilot, student pilot, or crew member?	❑	❑
B. Engaged or intend to engage in any sport or activity such as auto or motorcycle racing, skydiving, or scuba diving?	❑	❑
If you answered yes to A or B, please explain:		
5. Has any person covered by this policy been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	❑	❑
6. Has any person covered by this policy, during the past 5 years:		
A. Had kidney disease; blood, pus or sugar in the urine; prostate trouble; or any genito-urinary disorder or venereal disease?	❑	❑
B. Used, or been treated for abuse of sedatives, hallucinogenics, drugs, or alcohol, not otherwise prescribed by a physician?	❑	❑
C. Had any bone or joint disorder or disease, tumor, cancer, tuberculosis, or seizure disorder?	❑	❑
D. Had anemia, leukemia, or other disease of the blood?	❑	❑
E. Had any diabetes, liver disorder, ulcers, or other digestive disorder or disease?	❑	❑
F. Had any heart or circulatory disease, chest pain, stroke, hypertension, hernia, mental or nervous disorder, asthma, lung disease, or other respiratory disease?	❑	❑
G. Been a patient in or advised to enter a hospital, sanitarium, nursing home, or other institution for any reason, or had an operation?	❑	❑
H. Had a checkup, or currently taking any prescription drug (please list)?	❑	❑
I. Had any disease, condition, or other physical disorder or defect not mentioned above?	❑	❑

Continued on other side.

7. If the answer to any of the above questions is "Yes," give details, including diagnosis, dates, duration, names and address of all attending physicians and medical facilities. Attach separate sheet, if necessary.

8. Provide the height and weight of each person covered by this policy. _____

The above representations are true to the best of the knowledge and belief of the undersigned. All persons applying for reinstatement adopt, as their own, the above representations. It is agreed that this policy shall not be considered reinstated and the Company shall have no liability (other than to return payments made consequent to this application, without interest) until all money required for reinstatement of this policy has been paid and until this application has been approved by the Company at its Home Office during the lifetime and good health of all persons who would be insured under this policy if reinstated. It is agreed that the date of approval by the Company shall be the Date of Reinstatement. It is further agreed that reinstatement of this policy, if granted by the Company, shall 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. It is agreed that all past due premiums must be paid where applicable.

_____ _____

Signature of Principal Insured | Signature of Owner if other than Principal Insured

_____ _____

Witness Signature (Non-Family Member) | Signed at City State Month/Day/Year

❑ If box is checked, witness must be a non-family member notary public.

Subscribed and sworn to before me this_____day of _____, 20_____

_____(Notary Public) Commission Expires _____