



# United Home Life Insurance Company

225 South East Street • P.O. Box 7192  
Indianapolis, Indiana 46207-7192

## Application for Reinstatement

Please print information legibly

File # _____	
Proposed Insured _____	Social Security # _____
Billing Address _____	Telephone # _____
Owner (if other than proposed insured) _____	Social Security # _____
Billing Address _____	Telephone # _____
Since this policy was issued has any proposed insured person(s):	
a. Been treated by or consulted a physician for: high blood pressure, heart, lung, kidney, intestinal, or liver disease, or, for the nervous system, epilepsy, diabetes, chest pain, cancer or tumor any kind, convulsions, or rheumatic fever? (circle any and all that pertain and give complete details)	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Taken or been advised to take any medication(s)? (please list by name and dose)	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Received advice, treatment, or been arrested for the use of alcohol or drugs or been a patient in any hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Used nicotine in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Been diagnosed or treated by a physician for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex), or any other immunological disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Give details to all "YES" answers including name(s), address(s), and phone number(s) of physician(s) treating and/or prescribing medication(s):	

The primary insured and owner, if other than the primary insured, declare that all answers given above, and details are complete and true. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or any other organization, institution or person(s), that have any records or knowledge of me or my health, to give to United Home Life Insurance Company any such information.

**DO NOT SIGN A BLANK FORM**

Signed at \_\_\_\_\_  
(City, State)

Date \_\_\_\_\_

Witness \_\_\_\_\_  
(Soliciting agent or other witness)

X \_\_\_\_\_  
Signature of Proposed Insured

Agent Code \_\_\_\_\_

Agent Phone # \_\_\_\_\_

X \_\_\_\_\_  
Signature of Owner, if other than proposed insured

Agent Fax # \_\_\_\_\_

***DISCLAIMER: All above questions must be answered and complete details must be given. Failure to do so may result in a delay in the review of your file for reinstatement consideration.***

**Please complete the back of this form for billing purposes.**

**IMPORTANT: All past due premiums must be paid current before an application for reinstatement will be reviewed. If a billing option is not specified and your application is approved, then the policy will be billing quarterly direct.**

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**DIRECT PAYMENT OPTIONS** *(Direct Monthly Billing not available)*

QUARTERLY

SEMI-ANNUAL

ANNUAL

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**MONTHLY BANK DRAFT**

TO BEGIN MONTHLY BANK DRAFT, THE AUTHORIZATION BELOW MUST BE COMPLETED AND ACCOMPANIED BY A CHECK MARKED "VOID."

THE MONTHLY DRAFT DATE WILL BE THE SAME AS THE POLICY DATE UNLESS INDICATED.

\_\_\_\_\_  
Bank Name

\_\_\_\_\_  
Bank Account Number

\_\_\_\_\_  
Bank Routing Number

\_\_\_\_\_  
Bank Address: City/State/Zip

Requested Draft Date (1st – 30th) \_\_\_\_\_

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**AUTHORIZATION TO HONOR CHECKS DRAWN BY  
THE UNITED HOME LIFE INSURANCE COMPANY  
Indianapolis, Indiana**

As a convenience to me, I hereby request and authorize you to pay and charge to my account, debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice, I agree that you shall be fully protected in honoring any such debit entry.

I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

\_\_\_\_\_  
Date

X \_\_\_\_\_

Signature of Premium Payor  
(name must appear on void check)