PRIMERICA®

**Primerica Life Insurance Company**
Executive Office: 1 Primerica Parkway
Duluth, Georgia 30099-0001
1-800-257-4725

# Reinstatement Application for Individual Term Life Insurance

Policy Number | Driver's License Number | State | Social Security Number

Name of Primary Insured (Print)

Street Address/Apt. No.

City | State | ZIP

Country | Day Telephone Number | Evening Telephone Number

Amount Submitted With Reinstatement
$_____

**REINSTATEMENT:** *Increases to coverage are contestable per the policy's incontestability provision.*
☐ *Original Date (All Back Premiums Are Required)*
☐ *Redate (Current Mode Of Premium Or New Signed Voided Check Required)*

*You have two options to reinstate your policy. For the first option (original date), you must pay all unpaid, past due premiums with interest and the reinstated date of your policy will be the same date as your original policy date. By choosing this option, you will keep your original issue age. If you do not want to pay all past due premiums with interest, you may choose the second option (redate). For this option, you will pay one month's premium and you will be given a new anniversary date. By choosing this option, your insurance age may change and your premiums may increase. Regardless of the election made above, there will be a new two (2) year contestable period that begins with reinstatement.*

1. What is the Primary Insured's present occupation? Give exact duties.

2. Within the past 3 years has any person named in this application been treated for or diagnosed by a member of the medical profession with: ☐ Yes ☐ No
   a. Hypertension (high blood pressure)?
   b. Stroke; diabetes; cancer; tumor; paralysis; multiple sclerosis; lupus; scleroderma; rheumatoid arthritis; muscular dystrophy; leukemia; lymphoma (Hodgkin's and Non-Hodgkin's); seizure; mental or nervous disorder?
   c. Any disease or disorder of the heart (excluding hypertension); liver (including hepatitis); pancreas; blood; brain; kidneys; circulatory; respiratory; gastrointestinal; neurological or nervous system?

   If yes, specify who and give complete details including diagnosis(es), date(s), duration(s) and complete name and address of all attending physicians.

3. Do you or any other person insured under the policy currently take prescription medication or have any impairments or disabilities? If yes, specify who and give complete details including medication. ☐ Yes ☐ No

4. Have you or any other person insured under the policy ever been diagnosed, treated, or tested positive for Human Immunodeficiency Virus (AIDS virus), or Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession? If yes, specify who and give complete details. ☐ Yes ☐ No

5.a. Have you or any other person insured under the policy (excluding children) used tobacco/nicotine in any form in the last 12 months? If yes, specify who and give complete details. ☐ Yes ☐ No

b. Have you or any other person insured under the policy (excluding children) used tobacco/nicotine in any form in the last 5 years? If yes, specify who and give complete details. ☐ Yes ☐ No

6. Have you or any other person insured under the policy ever been convicted of a felony or a DUI? If yes, specify who and give complete details including date(s) and county and state. ☐ Yes ☐ No

## UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

By Our signatures below or by my electronic signature, if the electronic application process is used:

**(1)** We (Owner, Applicant and all Insured(s)) authorize Primerica Life Insurance Company, its affiliates, (collectively the "Company") reinsurers, and authorized representatives, including agents, insurance support organizations and service providers to receive our health information;

**(2)** We acknowledge that health information may include information about prescription histories, the diagnosis, treatment and prognosis of any physical or mental condition and the use of drugs or alcohol, but not psychotherapy notes;

**(3)** We authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, Veteran's Administration, government facility, pharmacy, pharmacy benefit manager, insurance company, clearinghouse, or other entity or person ("Providers") to disclose our health information;

**(4)** We acknowledge that this Authorization may be relied upon to determine our eligibility for insurance, to obtain reinsurance, to administer any claim for insurance benefits or for any other business purpose not otherwise prohibited, including but not limited to any activities related to coverage or benefits or to support the business operations of the Company;

**(5)** We acknowledge that this Authorization expires two (2) years from the date it is signed;

**(6)** We acknowledge that we may revoke this Authorization at any time by sending written notice to the Company's address, however, any revocation will not apply retroactively or prevent the Company from contesting a claim for insurance benefits or the policy itself;

**(7)** We acknowledge that if we refuse to sign this Authorization, a Provider may not refuse to provide treatment or payment for health care services, however, the Company may not be able to process this application or, if coverage is issued, make any benefit payments;

**(8)** We acknowledge that information disclosed pursuant to this Authorization may be redisclosed and no longer covered by certain federal rules governing privacy of health information; and

**(9)** We acknowledge that a photographic copy of this Authorization, including a photographic or electronic copy of Our signature, is valid as the original and We may receive a copy of this Authorization after it is signed.

By signing this Application, We (Applicant and all Insured(s)) represent that; **(1)** All of the information in this Application and all additions to this Application are true and complete to the best of Our knowledge and belief; **(2)** The statements and answers in this Application are the basis for and become a part of the policy, and no information about Us will be considered to have been given unless it is stated in this Application; and **(3)** We will accept return of any amount paid herewith should the Company decline to approve this Application. We also agree and understand that: **(1)** Primerica agents do not have the authority to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of this Application, policy or receipt; **(2)** There is no Conditional Coverage and that the Company shall have no liability until (a) a policy is issued on this Application and delivered to and accepted by Us; and (b) and the first premium is paid in full while each proposed insured is alive; **(3)** If any statement made herein be in any respect untrue, the Company shall be under no liability for a period of two years from the date of reinstatement; **(4)** We have received, read, understand and consent to the terms of the Health Insurance Portability and Accountability Act (HIPAA), Authorization For Use and Disclosure of Protected Health Information; and **(5)** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents a false statement in an insurance application may be guilty of a criminal offense and subject to penalties under state law. We also authorize: **(1)** the Company to request investigative consumer reports and motor vehicle reports on Us; and **(2)** the Company and its reinsurers to request our medical information from MIB, Inc. and its members.

Dated at _____ this _____ day of _____ ,
State

✗ _____
Signature of Primary Insured

✗ _____
Signature of Spouse Rider Insured (If to be Insured)

✗ _____
Signature of Owner (If other than Primary Insured)

Policy Owner Email Address _____

Agent's Name* Solution Number*

*Agent's name and solution number is not a part of this application.