Life Reinstatement Application To:

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

PO Box 1365 Columbia, SC 29202

Insured Section

Insured's Name (First, MI, Last)				Birthdate (mm/dd/yyyy)	Social Security #
John Doe				01/01/1990	111-11-1111
Home Address – Street	**City**	**State**	**Zip Code**	**Email Address**	
123 Any Street	Any City	Any State	12345	jdoe@anyemail.com	
Occupation				State of Birth	Primary Phone #
worker				Any State	555-555-5555

Spouse/Dependent Section – complete if spouse or dependent children are covered under any rider(s) requested for reinstatement.

Name (First, MI, Last)	**Birthdate (mm/dd/yyyy)**	**Social Security #**	**Current Height and Weight** (only for Spouse)

List Life Policy Number for all policies requested for reinstatement

12345678910		

If your coverage has lapsed because you were on a leave of absence from work that qualifies under the **Family and Medical Leave (FMLA) Act of 1993,** it is not necessary for you to answer the questions below. You only need to have your employer verify the leave dates in the designated space below and sign and date where indicated. Coverages that are reinstated as a result of the FMLA Act will cover losses occurring on or after the date you return to your employment after the period of FMLA leave as certified by your employer.

NOTE: This application must be completed and certified by your employer immediately upon your return to work.

If FMLA dates of leave are **longer than** 120 days or the application sign date is 30 days past the return to work date, application questions must be completed.

Period of FMLA leave _____
From (mm/dd/yyyy) To (mm/dd/yyyy)

_____ _____ _____ _____
Employer's Signature Date (mm/dd/yyyy) Employee's Signature Date (mm/dd/yyyy)

Application Questions – For any "Yes" answer to questions 4-7, please provide complete details in the Additional Data Section. If Long Term Care or Accelerated Death Benefit for Chronic Care rider(s) are requested to be reinstated, complete questions 8 and 9

1. Insured's Current Height: __6'0"_____ Insured's Current Weight: __200_____	
2. Is the Insured actively working? If "No", is the Insured disabled or unable to work?	Yes ☒ No ☐ Yes ☐ No ☐
3. Within the past 12 months has the proposed insured used tobacco in any form or any nicotine delivery system, including electronic devices, nicotine substitutes, or smoking cessation products, or any electronic device that does not contain nicotine including electronic vaporizers or cigarettes?	Yes ☐ No ☒
4. Within the past 5 years, has any insured applying for reinstatement under the policy(s) listed above: a) been declined, postponed or offered insurance on a modified or rated basis? b) been in a hospital or other institution for observation, diagnosis, operation or treatment, including inpatient, outpatient or emergency room? c) had or now has any abnormality, deformity, disease or disorder for which advice or treatment has been received from a member of the medical profession?	 Yes ☐ No ☒ Yes ☐ No ☒ Yes ☐ No ☒
5. Within the past 2 years has the insured used marijuana, narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit-forming drugs, except as prescribed by a member of the medical profession; or received medical advice or treatment for drug and/or alcohol abuse?	Yes ☐ No ☒
6. Within the past 2 years has the insured been convicted of operating a motor vehicle under the influence of drugs and/or alcohol; pled guilty, no contest to, been convicted of or have a charge pending for a felony or misdemeanor; or are currently on parole or probation?	Yes ☐ No ☒
7. Is the insured prescribed any medication? Please list disorder or disease, name of medication and dosage.	Yes ☐ No ☒
8. Does the insured need assistance, supervision, or use equipment or adaptive devices to perform any of the following activities: bathing, continence, dressing, eating, toileting, or transferring?	Yes ☐ No ☐
9. Has the insured ever been diagnosed with, received medical advice or received treatment from a member of the medical profession (including medication) for: osteoporosis, rheumatoid arthritis, chronic fatigue syndrome, Parkinson's disease, Alzheimer's disease or dementia?	Yes ☐ No ☐

Additional Data Section

For yes answers, provide details below.

Condition Name / Medication Name & Dosage	Diagnosis Date and Duration	Doctor/ Hospital Name, Address & Phone #	Date of Treatment	Type of Treatment Received

Agreement Section

THE APPLICANT AGREES AS FOLLOWS:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. The answers and statements above are true and complete to the best of my knowledge and belief. All persons applying for reinstatement adopt the above representations as their own. 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 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. I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

Caution: If your answers on this application are incorrect or untrue, Colonial Life & Accident Insurance Company has the right to deny benefits or rescind your policy.

Signed at: City___Any City_____ State _Any State_____ Date __01/01/2018_____
(mm/dd/yyyy)

(x)__*John Doe*_____ (x)_____
Signature of Insured Signature of Owner (if Other than Insured)