REQUEST FOR REINSTATEMENT OF POLICY CONTRACT

Check One:

P.O. Box 320609
Flowood, MS 39232-0609

Phone: 601.346.2766
Toll Free: 800.826.6803
Fax: 866.665.0238

☐ **SECURITY NATIONAL LIFE INSURANCE COMPANY**

☐ **MEMORIAL INSURANCE COMPANY OF AMERICA (MICOA)**
Administered by Security National Life Insurance Company

☐ **SOUTHERN SECURITY LIFE INSURANCE COMPANY, INC. (SSLIC)**
Administered by Security National Life Insurance Company

☐ **FIRST GUARANTY INSURANCE COMPANY, INC. (FGIC)**
Wholly-Owned Subsidiary of Security National Life Insurance Company

Policy Number: _____

This information is required to determine if you are eligible for the reinstatement of your policy. It is imperative that you fill out all questions and put any information concerning your health on this form to ensure proper coverage.

Name of Insured:_____

Social Security Number: _____ Height: _____

Date of Birth: _____ Weight: _____

Address: _____

_____

Telephone Number (including Area Code): _____

Name of Owner: _____

Owner Address, if different: _____

_____

I hereby certify that the medical information supplied on this form is complete and accurate. There has been no material change in the status of my health or physical condition since the time of my original application. I have completed the Health Certificate on the second page of this form. By signing this form, I authorize my doctor, hospital or related facility, pharmacy benefit manager, insurance company, person or organization, having records of me or my family, to give Security National Life Insurance Company and its representatives any such information. Such records or information will be used by company personnel to determine eligibility for insurance and/or benefits. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. A reproduction of this authorization shall be valid as the original. This authorization shall be valid for two (2) years from the date signed. This authorization may be revoked upon submission of a written notice to the home office.

_____ _____

Signature of Insured Date

_____ _____

Signature of Owner, if other than the Insured Date

Recorded at Security National Life Insurance Company

By:_____

Date:_____

HEALTH CERTIFICATE
All Questions to be answered by Insured

Has proposed insured ever had or been advised of having:	YES	NO
A. High Blood Pressure, Stroke, Paralysis, Heart Trouble?	☐	☐
B. Kidney Trouble, Diabetes, Blood or Sugar in the Urine?	☐	☐
C. Cancer, Tumor or Growths requiring removal?	☐	☐
D. Nervous Disorder, Mental Trouble, Epilepsy or Brain Disease?	☐	☐
E. Ulcer, Gallstones, Cirrhosis of the Liver or other Diseases of the Digestive Tract?	☐	☐
F. Tuberculosis, Emphysema or Other Respiratory Diseases?	☐	☐
In the past ten (10) years, have you:		
1. Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARCS) or AIDS-related conditions?	☐	☐
2. Received advice or treatment in connection with any of the categories mentioned above (in item 1)?	☐	☐
3. Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, Type III, HTLV-III virus?	☐	☐
Has any application for insurance on the life of the proposed insured ever been declined, cancelled, postponed or rated?	☐	☐
Is the proposed insured blind, or partially blind in either eye, or is a limb missing?	☐	☐
Does the proposed insured presently have any illness or disability not already mentioned?	☐	☐
Has the proposed insured been to a doctor or hospital within five (5) years?	☐	☐
Is the proposed insured presently taking medication?	☐	☐
Has the proposed insured been treated for Alcohol or Drug abuse?	☐	☐
Has the proposed insured been diagnosed with or been treated for a Terminal Illness?	☐	☐
Are you currently bedridden or residing in a nursing or long-term care facility?	☐	☐

If you answered “YES” to any of the above, please provide details below of condition, disease or impairment, dates of onset, duration, and treatment administered. Include all medications and dosages.

_____

_____

_____

_____

_____

Name and Mailing address of Doctor, Hospital or Treatment facility: _____

_____

_____

I HAVE READ THE ABOVE QUESTIONS AND ANSWERS. I AGREE THEY ARE TRUE, COMPLETE AND CORRECTLY RECORDED TO THE BEST OF MY KNOWLEDGE AND BELIEF. All statements contained in this policy change form shall be deemed representations and not warrantees. I understand and agree that the insurance reinstatement applied for will not take effect until and unless the premium has been submitted in full and the insured named and covered is living as of the date of approval.

I hereby authorize any medical practitioner, hospital, clinic or other medical 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 to Security National Life Insurance Company, or its reinsurer, any such information.

A photographic copy of this authorization shall be as valid as the original.

_____ _____

Signature of Insured Date

_____ _____

Signature of Owner, if other than the Insured Date