THE CINCINNATI LIFE INSURANCE COMPANY

Headquarters: 6200 S. Gilmore Road, Fairfield, OH 45014-5141
Mailing address: P.O. Box 145496, Cincinnati, OH 45250-5496
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APPLICATION FOR INDIVIDUAL LIFE INSURANCE REINSTATEMENT **Policy #** _____

FRAUD WARNING: 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.

Please print or type all information

INSURED

1. Name of Proposed Insured (first, middle, last) | 2. Social Security Number
3. Gender ☐ M ☐ F | 4. Birthdate | 5. Birthplace (state) | 6. Driver's Lic. No./State
7. Street Address | Apt. # | City | State | Zip
8. Phone Home _____ Work _____ Cell _____ Email _____
9. Is the Proposed Insured actively employed? ☐ Yes ☐ No (If "No," please explain in #22)
Occupation _____ Employer _____ Hours Per Week _____

CTR

10. **CHILDREN'S INFORMATION**
Complete if you have Children's Term Rider

Name	Gender	Date of Birth	Height	Weight
			___ ft ___ in	___ lbs
			___ ft ___ in	___ lbs
			___ ft ___ in	___ lbs
			___ ft ___ in	___ lbs

Other than a routine physical, has any child been treated by a physician or medical practitioner or been hospitalized in the past two years? (If "Yes," please explain in #22) ..... **YES** ☐ **NO** ☐

PERSONAL HISTORY

GIVE FULL DETAILS (IN #22) TO ANY QUESTIONS ANSWERED "YES"

11. Has the Proposed Insured: **YES** **NO**
a. In the last two years, flown, or within the next two years, intend to fly as a pilot, student pilot or crew member? ..... ☐ ☐
b. Traveled or resided outside the USA or Canada in the last two years, or have any intention of traveling or residing outside the USA or Canada within the next two years? ..... ☐ ☐
c. Engaged in sky or scuba diving, hang gliding, rock climbing or any form of motorized racing in the last two years, or have any intention of engaging in any of these activities within the next two years? ..... ☐ ☐
d. Ever used heroin, cocaine (including crack), LSD, PCP, amphetamines, barbiturates, marijuana, any derivative of these drugs or any controlled substance except as prescribed by a medical professional? ☐ ☐
e. Ever received or been advised by a physician to seek counseling for alcohol and/or drug abuse? ..... ☐ ☐
f. Ever been rated or declined for insurance or been denied reissue or reinstatement of a policy? ..... ☐ ☐
g. Ever pleaded guilty to or been convicted of a felony or misdemeanor or have such charge currently pending against them? ..... ☐ ☐
h. In the last three years, pleaded guilty to or been convicted of moving violations? ..... ☐ ☐
i. Ever been convicted of driving while intoxicated or driving under the influence of a controlled substance or ever had his/her license suspended or revoked? ..... ☐ ☐

12. Does the Proposed Insured belong to or have they entered into a written agreement to join any component of the armed forces including reserves or National Guard? ..... **YES** ☐ **NO** ☐

13. Has the Proposed Insured ever filed for bankruptcy? (If "Yes," list chapter filed and date(s) discharged) _____ **YES** ☐ **NO** ☐

14 Height _____ ft _____ in Weight _____ lbs

PERSONAL HISTORY

GIVE FULL DETAILS (IN #22) TO ANY QUESTIONS ANSWERED "YES"

15. Has the Proposed Insured ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any of the following? (If "Yes," check the items that pertain) ..... **YES** ☐ **NO** ☐

- ☐ Stroke
- ☐ Diabetes
- ☐ Disease of the reproductive organs
- ☐ Hepatitis
- ☐ Auto immune disease
- ☐ Cancer or tumor of any kind
- ☐ Muscle or connective tissue disorder
- ☐ Spine, back or joint disorder
- ☐ Seizure disorder
- ☐ Anxiety, Depression
- ☐ Bone disorder
- ☐ Sleep disorders, Sleep apnea
- ☐ Prostate disorder
- ☐ High blood pressure
- ☐ Lung or respiratory disorder or disease
- ☐ Digestive system disorder
- ☐ Skin disorder
- ☐ Chest pain
- ☐ Psychiatric, Mental or nervous disorder or disease
- ☐ Disorder or disease of the blood or lymph nodes
- ☐ Dizziness, fainting or headache
- ☐ Kidney or bladder disease or disorder
- ☐ Thyroid or other endocrine disorders or disease
- ☐ Disorder or disease of the heart, blood vessels or circulatory system

16. Has the Proposed Insured: **YES** **NO**

a. In the last five years, been hospitalized or consulted, been examined or treated by any physician, psychiatrist or other medical professional not disclosed in response to the prior questions? ..... ☐ ☐

b. Ever been diagnosed by a medical professional or tested positive as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? ..... ☐ ☐

c. In the last five years been an inpatient or outpatient in a hospital, clinic or medical facility, or any similar entity? ..... ☐ ☐

d. Ever been diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia?. ..... ☐ ☐

e. In the last five years been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? ..... ☐ ☐

17. Female only: Is the Proposed Insured now pregnant? ..... **YES** ☐ **NO** ☐

18. Has the Proposed Insured ever used tobacco or nicotine products? (If "Yes," complete the following) .... **YES** ☐ **NO** ☐

	Present	Quit (date)	# Packs Per Day	Present	Quit (date)
Cigar	☐	_____	Cigarettes _____	☐	_____
Pipe	☐	_____	Patch, gum, ecigarette, hookah,		
Smokeless	☐	_____	vapor stick or other nicotine products	☐	_____

19. Is the Proposed Insured taking any prescribed or non-prescribed medication or herbal treatment? ..... **YES** ☐ **NO** ☐

20. Proposed Insured's Regular Attending Physician (If "None," so state)

_____ Name

_____ Address

_____ Phone #

_____ Date of Last Visit

_____ Reason of Last Visit

_____ Result of Last Visit

21. Have either of your parents, brothers or sisters died from, or been diagnosed by a medical professional as having, heart disease or cancer before age 60? (If "Yes," identify family members, disorder and age at death in #22) ..... **YES** ☐ **NO** ☐

DETAILS

22. **DETAILS OF "YES" ANSWERS:** Identify question number and include diagnosis, dates, duration, treatments and medications prescribed and names and addresses of all medical professionals and hospitals.

_____

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EXISTING COVERAGE

23. **List all life insurance policies or annuities in force with The Cincinnati Life Insurance Company or any other company, including any applications pending, and indicate if any are to be replaced, changed or borrowed against as a result of this Application. If no other insurance in force, please indicate none.**

Insurer	Policy Number	Amount	Replaced? YES	Replaced? NO	Personal or Business? P	Personal or Business? B
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

Complete any applicable replacement forms.

AGREEMENT

AGREEMENT: I have read the statements and answers in this application. To the best of my knowledge and belief, they are complete and true. I agree that reinstatement is based on statements in this application and in the original application. I agree reinstatement is contingent on payment of all required premiums plus interest and on approval by The Cincinnati Life Insurance Company. I agree that, in the event of reinstatement, the time limit in the policy's incontestability and suicide clauses and any defense available to The Cincinnati Life Insurance Company shall begin again with respect to statements made in this application. No provision of this reinstatement application or the policy can be modified or waived except by an endorsement signed by an officer of The Cincinnati Life Insurance Company. I will notify The Cincinnati Life Insurance Company of any changes in the statements or answers given in this Reinstatement Application between the time of the Application and approval of reinstatement. If reinstatement is not approved, any amount paid with this application will be refunded.

I acknowledge having received and read the Important Notice to the Proposed Insured.

Signed at _____ (City) _____ (State) On _____ (Month Day Year)

_____
Signature of Proposed Insured (if below age 15, signature of parent or guardian required)

_____
Witness (To all signatures)

_____
Owner (if not signing above) If a firm or corporation, print company name and have company officer sign.