Please print and sign this document and return via mail or fax to LifeHelp with payment.

United States Life Health Statement

Reinstatement Form for Life Insurance Coverage

To reinstate your policy, United States Life Insurance Company's guidelines require that we receive this signed statement with your payment within 90 days of your last premium due date.

I hereby certify the following:

1. During the past 2 years I have not had a consultation or examination with a physician or other medical practitioner except as listed under the exceptions below. This includes self-diagnosis if I am a medical professional.

2. I have not made an application for insurance that has been declined, postponed, or modified during the past 2 years.

EXCEPTIONS: ____

____

____

Please fill in the member information, sign, date and return this statement with your payment.

Member Information:

Member Name: ______________________________

Credit Union: ______________________________

Member's Address: ______________________________

City, State ZIP: ______________________________

Member Phone Number: ______________________________

I understand and agree that this reinstatement of my Life Insurance coverage is conditioned on the truthfulness of the above statements. I further agree that if within 2 years after the signing of this form the Company discovers any misrepresentations in the statements contained herein, the Company shall have the right to declare any approval null and void and of no effect except for the return of all premiums paid since the signing of this form.

____ ____________________

Signature of Applicant **Date**

Return completed form and payment to:

LifeHelp • P.O. Box 492517, Redding, CA 96049-2517 • FAX: (530) 223-7712