



P.O. Box 1756, Des Moines, IA 50306-1756
800-477-3633

**APPLICATION
FOR
REINSTATEMENT
BY
REDATE**

Policy # _____

Insured _____

I request reinstatement by redate of the above-referenced policy. I hereby certify that the insured is living as of the date of this application. I also agree to complete the following section truthfully and to the best of my knowledge. If this properly completed form is received at our Home Office within 120 days from the date premiums were discontinued, you are not required to answer either health question below. However, if you do answer either question, we will rely on your answers in considering the reinstatement of this policy.

Has the person insured under this policy been treated for, or advised to be treated for, any health-related condition since the date of the original application? If the insured is still being treated or monitored for a condition that existed when this policy was originally issued, please check yes.

Yes _____ No _____

If yes, indicate below all health-related conditions, date(s) and duration, and the name and address of the attending physician(s). This information is required even if it was previously indicated on the original application.

The undersigned has full knowledge that the policy could be reinstated to its previous terms and conditions by payment of all past due premiums. In lieu thereof, I hereby agree to waive the right to reinstate as above and elect to pay the premium that would be due based upon the insured's current age. I will receive a new policy with the original issue date adjusted to reflect the past due premiums that will be added to the end of my current payment term. This will become the new issue date. If the new issue date results in a higher issue age, I understand the company will require me to pay any difference in premium since the new issue date.

I further agree that if the insured's age has changed prior to the new issue date, the company will adjust those terms and conditions necessary to reflect the new issue age. I understand that upon reinstatement and reissuance of the policy, the current value of all benefits may be less than those prior to premium default.

I understand that:

- The policy shall not be reinstated until this application is received and approved by the Home Office of Homesteaders Life Company, Des Moines, Iowa, during the lifetime of the insured.
- No premium paid in advance to reinstate the policy shall be binding on the company until the reinstatement application is received and approved by the Home Office.
- Homesteaders has the right to contest this application for a period of two (2) years from the date of reinstatement for misrepresentation of material facts.
- A maximum of 2 redates are allowed during the life of the policy.

Today's Date: _____

Signature of Policy Owner

Address _____

City _____, State _____ Zip _____

Phone # _____