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

APPLICATION FOR REINSTATEMENT

Policy #_____

Insured _____

I request reinstatement of the above-referenced policy. I agree to pay all past due premiums, and 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.

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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.

Today's Date: _____

_____
Signature of Policy Owner

Address_____

City_____, State_____ Zip_____

Phone #_____