American Income
life insurance company

Reinstatement Form

Reinstatement forms older than 15 days will not be accepted. All policies require *at least* one month's premium.

Submit to the appropriate email address:
Reinstatements@AILife.com (Checkless) and AILReinstatements@AILife.com (Virtual/Docusign)

Send Priority and Overnight Deliveries to:
American Income Life, ATTN: Customer Retention Reinstatements, PO Box 2608, Waco, TX 76702

Good Health Statement

To the best of my knowledge and belief, every person insured by these policies are in good health as recorded below for each insured, and there has been no change in the condition of any person since the date of the original application. No such person has consulted a physician or been hospitalized in the last year. Any exceptions indicated below are listed in the Exceptions Section.

Policy Information Please complete all fields for each policy you wish to reinstate.

Policy Number		Insured Name
Good Health ❑ Yes ❑ Exception	Reinstatement Type ❑ Redate* ❑ Waive (Only FY) ❑ Reinstatement (No Waiver) ❑ Conservation Notice	
Life ❑ Yes ❑ No	Recode ❑ Yes ❑ No	Premium Collected for this Policy
Instructions		
Policy Number		Insured Name
Good Health ❑ Yes ❑ Exception	Reinstatement Type ❑ Redate* ❑ Waive (Only FY) ❑ Reinstatement (No Waiver) ❑ Conservation Notice	
Life ❑ Yes ❑ No	Recode ❑ Yes ❑ No	Premium Collected for this Policy
Instructions		
Policy Number		Insured Name
Good Health ❑ Yes ❑ Exception	Reinstatement Type ❑ Redate* ❑ Waive (Only FY) ❑ Reinstatement (No Waiver) ❑ Conservation Notice	
Life ❑ Yes ❑ No	Recode ❑ Yes ❑ No	Premium Collected for this Policy
Instructions		
Policy Number		Insured Name
Good Health ❑ Yes ❑ Exception	Reinstatement Type ❑ Redate* ❑ Waive (Only FY) ❑ Reinstatement (No Waiver) ❑ Conservation Notice	
Life ❑ Yes ❑ No	Recode ❑ Yes ❑ No	Premium Collected for this Policy
Instructions		

Exceptions

Name	Ailment, Illness or Change	Date	Physician or Hospital and Address

American Income Life Insurance Company or its reinsurer may obtain medical and other information from the MIB to evaluate my application for insurance. Information may also be obtained from consumer reporting agencies including information from any pharmacy or pharmacy benefits manager that possesses prescription history about me. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization shall remain in force for 24 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to American Income Life Insurance Company. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I acknowledge that I have received an Investigative Consumer Report Notification and MIB notice. I further acknowledge that American Income Life Insurance Company may report information to the MIB or to other insurers which I have or may apply. No agent may bind, alter, change or waive any underwriting requirements or other provisions of the policy. Final acceptance is made by the Underwriting Department of the Company.

I wish to reinstate the above policy(ies). By completing this form, I am authorizing American Income Life Insurance Company to immediately draft the amount owed, including future drafts on the selected draft date.

Once your policy(ies) have been reinstated, we will resume drafting for premium on the original draft date that you selected at the time the original application was completed unless a new date is chosen under the Checkless Authorization section below. Please note that the first regular monthly draft could be immediate depending on the chosen draft date.

***I FULLY UNDERSTAND THAT REDATING MY POLICY MAY CAUSE MY COVERAGE TO DECREASE BASED ON INSURABLE AGE.**

Signature of Insured	Print Insured Name	Date
Signature of Insured's Spouse	Print Insured's Spouse Name	Date
Signature of Insured Child (18 and Over)	Print Insured Child Name (18 and Over)	Date
Signature of Payor (must be bank account owner)	Print Payor Name (must be bank account owner)	Date

Checkless Authorization

Policy Number(s) _____

Banking Institution _____

City _____ State _____

Routing/Transit No. _____

Checking Account No. _____

Requested Draft Date (if any) _____

Signature of Bank Account Owner	Print Bank Account Owner Name	Date

Agent's Statement

I certify that I have asked all questions and truly and accurately recorded the information supplied by the Applicant.

X _____ Signature of Agent	Print Agent Name	Agent Number

Authorized Signature required for all Recode requests.

Signature of Authorized Signer	Print Authorized Signer Name

Investigative Consumer Reports Notification
As part of our routine underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through consumer reporting agencies, The Department of Motor Vehicles, and personal interviews with your friends, neighbors, and associates. You may request to be interviewed in connection with the preparation of the report and upon request may receive a copy of the report.

MIB Notice
Information regarding your insurability will be treated as confidential. American Income Life Insurance, or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree Massachusetts 02184-8734.

American Income Life Insurance Company may also release information from its file to its reinsurers or to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Notice of Information Practices
Personal information may be collected from other parties. Such information, and other personal or privileged information later collected may be disclosed to third parties without authorization. You have the right of access and correction with respect to all personal information collected, and a full notice of your rights will be furnished upon request.