REOPEN REQUEST

Send to eAppREO@ailife.com for processing.

DATE: _____

Application Number(s): _____

Proposed Insured's Name: _____

Phone # Called/Address Visited: _____ Date Called/Visited: _____

Time Called/Visited: _____ Spoke To: _____

Relationship to Proposed Insured: _____

Total Authorized Amount to Draft for all Application Numbers Listed: $ _____

**If the policy was rated and/or had a premium miscalculation, please ensure the total authorized amount includes this premium.*

Bank Account Information - Required to complete. "Bill with" or "Use same on file" will not be accepted.

Bank or Institution Name: _____ Draft Date: _____

Routing #: _____ Account #: _____

Checking? ☐ Savings? ☐ Calling/Visiting Agent: _____

Recode? ☐ Yes ☐ No

Code to Agent #: _____ Code to Agent Name: _____

SGA Signature/Authorization to Recode: _____ Date: _____

By completing this form, the agent attests that he/she spoke with the applicant and authorization has been given verbally to draft for the amount listed above. Once authorized and processed by Home Office, production and advance may be given subject to 7 day hold provisions.

If the application is 3 + months old from the original application date, please complete the Good Health Statement.

Good Health Statement

To the best of my knowledge and belief every person insured by the policy(ies) is in good health, 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 are noted below:

☐ IN GOOD HEALTH ☐ EXCEPTION - The only changes in their (my) health are listed below:

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 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 this application or policy. Final application approval is made by the Underwriting Department of the Company.

_____ _____

Signature of Insured Date

_____ _____

Signature of Insured's Spouse Date