Family Liberty Life
— INSURANCE COMPANY —

FAMILY LIBERTY LIFE INSURANCE COMPANY
APPLICATION FOR REINSTATMENT

NAME_____ POLICY NUMBER _____

I, the undersigned, owner or payor of the above numbered policy, hereby pay to Family Liberty Life Insurance Company $ _____ to make application for reinstatement of same heretofore lapsed for non-payment of premiums, and in support of this application, represent, warrant and state that each and every one of said person(s) named on this policy and listed below are in good health and free from any chronic, infectious or contagious disease and are not sick nor suffering from any bodily ailment nor under the care or treatment of any physician or surgeon except as herein described:

INSURED NAME	ANNUAL PREMIUM	ILLNESS OR INJURY	ATTENDING PHYSICIAN	LAST VISIT TO/OR BY PHYSICIAN

I hereby declare that if any statements herein are untrue or if information is withheld regarding condition of health of the insured(s) and the policy reinstatement is granted then the same is and will be null and void.

This is also your authorization to consult and physician for information of a professional nature regarding the health of the insured(s) contained herein, if the benefit of the company. If this application is not approved, the payment hereby shall be refunded upon surrender of this receipt.

_____ _____

DATE SIGNATURE OF OWNER

PLEASE SIGN AND RETURN FORM VIA EMAIL OR U.S. MAIL AS SOON AS POSSIBLE.
HAVE QUESTIONS? CALL US AT 903-794-1300

This form was sent by _____ on this date_____ .

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