Going Beyond TOLIC
Trans-Oceanic Life Insurance Company Of America

Reinstatement Request Form

Please write legible.

I hereby request, subject to the provisions and policies of TOLIC, the reinstatement of the Policy (or Policies) under the name of _____, which were canceled due to non-payment for to the following reason:

☐ Sickness ☐ Disability ☐ Job Change ☐ Unemployment ☐ Retirement ☐ Account Changes ☐ Economical

☐ Account Unssuficient funds ☐ Other: _____

Have you, any of the dependents or additional insured, been treated, diagnosed, or have been made aware of problems or conditions of Cancer, Diabetes, Stroke, Heart Attack, or any heart condition in the last five (5) years?	☐ Yes ☐ No
Have you, any of the dependents or additional insured been treated or diagnosed by a licensed cancer or skin cancer doctor during the last ten (10) years?	☐ Yes ☐ No
If you have answered in the affirmative to any of the questions indicated above, the requested covers will be subject to approval in accordance with the Company's eligibility requirements.	

If my Reinstatement Request is approved, I authorize TOLIC to debit the monthly premium payment (according to my periodicity) of:

☐ Checking Account ☐ Savings Account	Account Number:	ABA Routing Number:
Financial Institution Name:	Branch Office:	Transfer Day:

☐ VISA ☐ MasterCard ☐ American Express	Card Number:	Security Code (CVC):
Exp. Date: MM/YYYY	Cardholder's Name:	Transfer Day:

I hereby state that all the answers and statements contained herein are complete in details and are true.	Signed in Date: MM / DD / YYYY

IMPORTANT NOTICE

Anyone who knowingly and with the intent to harm, commit fraud or mislead an insurer files aclaimor request containing false, incomplete or misleading information is guilty of a third-degree felony.

_____ Witness Signature

_____ Signature of the Insured Proposal

FOR OFFICE USE ONLY

Processed by: _____ **Date:** _____

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