



Please write legible.

I hereby request, subject to the provisions and p	olicies of TOLIC, the rein _with Person ID numbe		•	
non-payment for to the following reason:	_with cross in in hamber		, willoff wor	e dandered due to
☐ Sickness ☐ Disability ☐ Job Change ☐ U	nemployment Retire	ment \square A	ccount Changes 🔲 Eco	onomical
Other:	,		Ü	
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 skin cancer doctor during the last ten (10) years?				□Yes □No
If you have answered in the affirmative to any approval in accordance with the Company's eli		ated above,	the requested covers	will be subject to
If my Reinstatement Request is approved, I auth	orize TOLIC to debit the p	oremium pay	rment (according to my p	periodicity) of:
Checking Account Savings Account	Account Number:		ABA Routing Number:	
Financial Institution Name:				
☐ VISA ☐ MasterCard ☐ American Express	Card Number:		Security Code (CVC):	
Exp. Date:	Cardholder's Name:			
I hereby state that all the answers and statements contained he are complete in details and are true.		Signed in		
		Date: MM / DD /		Υ
Anyone who knowingly and with the intent to han false, incomplete or misleading information is gu	IMPORTANT NOTION ITM, commit fraud or mis Suilty of a third-degree fel	_	rer files a claim or requ	est containing
		Signature of the Insured Proposal		
	FOR OFFICE USE ONLY			
Processed by:		Date:		