American Century Life Insurance Company
1333 W. McDermott Dr. #200
Allen, TX 75013
Phone (855) 966-1111
Fax (855) 855-0181

Request to Reinstate Policy

(for form L-222A)

Name of Policy Owner: _____ Policy number: _____

Name of Insured: _____ Issue Date: _____

Please reinstate the above named policy effective at the date of this request.

Enclosed is a payment for $ _____ to cover the amount of premium due on the policy.

		Yes	No
1.	Does the Insured have a physical or mental condition that requires ongoing medication or medical treatment (excluding controlled high blood pressure, high cholesterol, or diabetes)? If "Yes," please provide additional details	☐	☐
2.	Is the Insured currently awaiting for a medical diagnosis or results from a medical test that have not been completed, or been advised to have surgery that has not been completed?	☐	☐
3.	Is the Insured currently or within the past year been hospitalized or confined to a nursing facility?	☐	☐
4.	Is the Insured bedridden, or confined to a wheelchair, or during the past year, have you had any type of amputation caused by disease?	☐	☐
5.	Within the past year, has the Insured had a heart attack, stroke or internal cancer?	☐	☐
6.	Within the past year has the Insured been treated for complications of diabetes, diabetic coma or insulin shock?	☐	☐
7.	Within the past year, have you been diagnosed with or treated for kidney failure, Alzheimer's disease, or had dialysis, or Cirrhosis of the liver?	☐	☐
8.	Within the past year, have you used oxygen equipment at home to assist in breathing?	☐	☐
9.	Has the Insured ever been HIV positive, or ever had or been treated for AIDS or ARC?	☐	☐

Current height: _____ Current weight: _____

List any medication you are currently taking, if any:

Medication Name & Dosage	Diagnosis/Condition

Medication Name & Dosage	Diagnosis/Condition

Policy Owner Signature _____ **Insured Signature** _____

Date _____ **Agent Signature** _____